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INTAKE FORM to be completed by all new clients and any former clients not seen in the past 12 months OR who are seeing a different therapist

TODAY'S DATE (MONTH/DAY/YEAR): _____

CLIENT NAME(S): (Last) _____ (First) _____
 (And parent names if (Last) _____ (First) _____
 client is a minor child) (Last) _____ (First) _____

If parents are separated, please identify custody arrangement: Joint Sole

Address: _____ City: _____ Postal: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____
 Messages OK? Yes No Messages OK? Yes No Messages OK? Yes No

COUNSELLING COSTS WILL BE COVERED BY:

___ **EMPLOYER/EFAP** – Company Name: _____

Employee's Name: _____

___ **PRIVATELY** (or by a parent or other Non-EAP 3rd party

___ **FIRST NATIONS/INUIT HEALTH BENEFITS (FNHIB)** – Treaty Number _____

ADDITIONAL COVERAGE is available through _____

SIGN ONLY IF YOU ARE REQUESTING FEE REIMBURSEMENT FROM AN INSURANCE PROVIDER

While I understand that *some* Counsellor, Social Worker or Psychologist fees are reimbursable by *some* insurance programs, I also understand that:

- I am responsible for paying the Therapist's fee at the time of each session and submitting my claim personally,
- Neither the Therapist nor PPC is responsible for denied claims.
- It is my responsibility to ensure that the Therapist I am seeing meets the criteria for my particular insurance policy,
- Obtaining such reimbursement is my personal responsibility, and is not the responsibility of PPC or my Therapist,

Client's Signature: _____ Date: _____

COMPLETE & SIGN ONLY IF A 3RD PARTY (PARENT OR OTHER NON-EAP) WILL BE PAYING FOR YOUR SESSIONS

For the purpose of account payment, authorization is given to release **LENGTH AND DATE OF SESSION only.**

to _____ (Name), who is my _____ (Relationship).

No authorization is given to release any session details

Client's Signature: _____ Date: _____

CLIENT/THERAPIST AGREEMENT FOR PROVISION OF COUNSELLING SERVICES between:

_____ (the “Client”) and _____ (the “Therapist”)

The Client agrees:

1. to provide 24 hours’ prior notice if canceling an appointment. (Voicemail can be left anytime) **Failure to provide 24 hours’ prior notice may result in a late cancellation fee of \$40.00 being charged to you personally.** Your prompt cancellation will permit someone else to use your time slot and thus reduce the waiting period for them;
2. to pay the Therapist’s fees before each session unless you are covered by an EFAP or FNIHB. In case of payment rejection by your EFAP, you are responsible for paying the Therapist’s fees. **If you are requesting coverage through an insurance policy, you are responsible for paying the full fee and submitting your claim personally. It is the Client’s responsibility to ensure your Therapist meets the criteria for your specific insurance policy.** Neither the Therapist nor PPC is responsible for denied claims. In instances of inactivity on unpaid accounts, the account will be turned over to a collection agency for payment;
3. if you subpoena your therapist or anyone at PPC, costs for court preparation, client rescheduling and court appearance(s) will be **paid by the client** at a rate of \$140.00 per hour.

The Therapist agrees:

1. to provide counselling assistance based upon the Client’s goals;
2. to maintain the confidentiality of the Client, unless:
 - a) you may be a danger to yourself or others, or there is a reasonable suspicion of child abuse or neglect. You recognize in such circumstances that I have a legal and ethical responsibility to my professional association to notify the proper authorities;
 - b) it is appropriate to consult with a professional colleague to improve the quality of my service to you; the information shared with this professional colleague will be kept anonymous and is restricted to the information necessary to aide in meeting your desired goals and to assist me in providing adequate service. This colleague will also be held to the rules of confidentiality.
 - c) you initiate a legal action whereupon I may use information from my records to defend myself.

By signing this Letter Agreement, you confirm that you have read and understand the terms set out above and that you agree to these terms. You also agree that your Therapist is an independent contractor and is providing services to you directly and personally. You also agree that this contract for the provision of counselling services is between you and the Therapist; that the Therapist is an Independent Contractor and is not an employee or agent of PPC; and that PPC is not providing counselling services to you. You also understand that your file will be destroyed within five (5) years of your last visit.

Client’s Signature _____

Therapist’s Signature _____

Date _____

Date _____

Answer only the questions below that apply to you, or that you are comfortable answering. If you are filling this form out on behalf of someone else, answers should be based on the client's point of view. Keep in mind that you will save much time and effort by giving us as much information as you can. **The facts on this form will be held in the strictest confidence.**

What is your **PRIMARY REASON** for attending counselling at this time (IE: Marital, Addiction, Family, Stress):

What are your **GOALS** for counselling? _____

How strongly do you want counselling for your problem? Very Strongly Strongly Moderately Could do Without

Are you seeing a counsellor anywhere else now? Yes No

Client's Date of Birth: _____ Age: _____ Sex: Male Female

Client's Occupation: _____ Years of Service: _____

Present marital status: _____ Spouse/Parent's Name(s): _____

Spouse's Date of Birth: _____ Age: _____ Sex: Male Female

Spouse's Occupation: _____ Names/Ages of Children: _____

Does your family know you are seeking counselling? ___ Spouse ___ Father ___ Mother ___ Children

Who referred you to PPC?

Self	EFAP	Psychologist/psychiatrist	Social agency	Relative
Hospital/clinic	Family doctor	Friend	Phone Book	Unsure

Years of formal education completed (include elementary, high school and post-secondary years): _____

Suppose an old friend ran into you once you complete counselling. What small changes would they see?

When your counselling goals have been met, what will you be doing differently? _____

Is there a family history of addiction? _____ Who? _____ Are they presently recovering? _____

Medications & Frequency: _____ Doctor's Name & Address: _____

SIGN here to authorize contact with your doctor regarding your involvement in counselling _____

Briefly describe the type of person your mother (or mother figure) was when you were a child and how you got along with her:

Mother's age: _____ Mother's occupation: _____ Mother's Religion: _____

If deceased, how old were you when she died? _____ Total number of times mother divorced _____

Briefly describe the type of person your father (or father figure) was when you were a child and how you got along with him:

Father's age: _____ Father's occupation: _____ Father's Religion: _____

If deceased, how old were you when he died? _____ Total number of times father divorced _____

If your mother and father separated, how old were you at the time? _____

I was child number _____ in a family of _____ children. Adopted: Yes No

Describe any identifying features in your relationship with your siblings: _____

Have any of your family of origin been treated for psychological symptoms? If so, please describe: _____

I would describe my attitude towards my job as:	Very Good	Good	Fair	Poor	Very Poor
My concentration on the job is:	Very Good	Good	Fair	Poor	Very Poor
The quality of my work is:	Very Good	Good	Fair	Poor	Very Poor
My relationship with my supervisor is:	Very Good	Good	Fair	Poor	Very Poor

Which statement most accurately describes the number of days you miss from work due to sick time:
___ Once a week or more ___ Once a month or more
___ Several times, but less than once a month ___ Once or twice a year ___ Never

Briefly describe the type and length of any previous therapy. (E.G.: talk therapy, drugs, hypnosis psychiatry, group, etc.), and what you found most helpful. _____

Briefly list any additional **past** problems, complaints or symptoms: _____

Under what conditions are your problems worse? _____ Improved? _____

Parts of yourself you are **satisfied** and **pleased** with?: _____

Any **social** difficulties?: _____

Any **love and sex** difficulties?: _____

Any **school or work** difficulties?: _____

Health complaints or limitations?: _____

Spiritual convictions?: _____

Have you ever felt the need to bet more money when gambling? Yes.....No

Have you ever lied about how much you gambled? Yes.....No

Have you ever quit drinking alcohol? Yes.....No

Have you ever been asked or told to quit drinking alcohol or using mood-altering drugs or medication? Yes.....No

Have you been hit, kicked, punched or otherwise hurt by someone within the past year? Yes.....No

Do you feel unsafe in your current relationship? Yes.....No

Is there a partner from a previous relationship who makes you feel unsafe now? Yes.....No

Name: _____
(Needed only if this page has been detached from Page 1)