INDIVIDUAL INTAKE ASSESSMENT – TELEPHONE AND ON-LINE

Print Form
Reset Form

Upon completing this Agreement, save it on your computer and then submit it using the "**SUBMIT A DOCUMENT**" link provided on our website.

impressions inc.
Family Counselling Services

P.O Box 27002 Langford
Victoria, BC V9B 5S4

Tel: (778) 557-8478
Toll: (886) 708-3501
Fax: (778) 557-8558

admin@impressions-counselling.org

GENERAL INTAKE ASSESSMENT

TELEPHONE AND ON-LINE TELECONFERENCING SERVICES

CONFIDENTIAL

This form and its contents are Protected, when completed, under the Health Services Act of Canada.

Please complete this *General Intake Assessment* and submit to your therapist, upon completion. This form is a mandatory requirement for services and must be completed by the individual, or their authorized representative. This form constitutes the "informed consent" of the individual identified and is utilized for the purposes of effective case management practices. No personal information or data collected is ever shared, unless required by Law under Court Order.

WELCOME TO IMPRESSIONS FAMILY COUNSELLING SERVICES INC.

YOUR RIGHTS AND RESPONSIBILITIES

- You have the right to good treatment – to be treated nicely, no matter what your state of mind or condition.
- You have the right to be treated respectfully and not be neglected, abused, have your feelings hurt or be yelled at.
- You have the right to privacy.
- You have the right not to be exploited. That is, your provider cannot use you or your case for his or her own personal gain.
- You have the right to treatment no matter your age, race, sex, religion, ethnic background or handicap. If this provider cannot treat you, for any reason, you have the right to be referred to a provider who can and will treat you.
- You have the right to know how your problems will be treated and what you can expect during the term of your treatment.
- You have the right to make choices throughout your counselling treatment plan.
- You have the right to refuse counselling intervention. If you say, "no" to a particular treatment, you have the right to know what might happen with or without the treatment.
- You have the right to have your records treated confidentially, and in accordance with the applicable Provincial and Federal Laws.
- If you have questions or do not agree with your treatment plan, you should discuss it with your provider.
- You have the responsibility to be on time for all appointments with your provider.
- You have the responsibility to give information to your provider if it's needed for your care.
- You have the responsibility to read and ask questions about your provider's terms and conditions of service prior to acknowledging and accepting these terms, as outlined in this Agreement, and to provide your authorization/consent for treatment with informed consent and full understanding of the Agreement terms.

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NAME: _____

APPOINTMENT DATE SCHEDULED: _____

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This form is a generalized intake assessment and case management data collection system for general counselling services for individuals.

NAME: _____ **TODAY'S DATE:** _____

LEGAL NAME: _____ *(if different from above)*

ADDRESS: _____ **GENDER:** M ☐ F ☐

_____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

BIRTHDATE: _____ **CURRENT AGE:** _____

IF YOU ARE 16 YEARS OF AGE OR YOUNGER, YOU REQUIRE THE CONSENT OF AN AUTHORIZED PARENT OR GUARDIAN TO CONSENT TO YOUR ON-LINE COUNSELLING SERVICES. SERVICES CANNOT BE PROVIDED WITHOUT THIS REQUIRED PARENTAL CONSENT.

PLEASE INDICATE YOUR CATEGORY BELOW:

YOUTH (10 TO 12 YEARS)	☐	*- Please complete below*
ADOLESCENT (13 TO 16 YEARS)	☐	*- Please complete below*
ADULT (17+ YEARS)	☐	*- Please skip to next section*
SENIOR (60+ YEARS)	☐	*- Please skip to next section*

I, _____ am the legal parent/guardian of the applicant identified on this on-line individual counselling services intake Agreement. I am fully aware of this request for counselling services and have consulted with this youth/adolescent to ensure that they are comfortable and satisfactorily informed to engage in this service. I hereby provide my authorization and full consent for:

_____

to participate in on-line counselling services with IMPRESSIONS Family Counselling Services Inc. I further acknowledge and accept the Conditions of this Agreement and have read and fully understand and accept responsibility for full compliance to the Terms of Service outlined in this Agreement.

PARENT NAME: _____ **PARENT BIRTHDATE:** _____ **PARENT PHONE:** _____

PARENT SIGNATURE: _____ **DATE OF SIGNATURE:** _____

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Family Counselling Services

NAME:

APPOINTMENT DATE SCHEDULED:

INSURANCE INFORMATION

Primary Health Insurance: _____ **Subscriber Name:** _____

Relationship to Subscriber: _____ **Subscriber Date of Birth:** _____

ID Number: _____ **Group/Policy Number:** _____

CURRENT TELEPHONE NUMBERS

Home: ( ) _____ **Phone Messages OK?** Yes ☐ No ☐

Work: ( ) _____ **Phone Messages OK?** Yes ☐ No ☐

Cell: ( ) _____ **Phone Messages OK?** Yes ☐ No ☐

MARITAL STATUS

- ☐ **Single**
- ☐ **Divorced**
- ☐ **Living as Married (_____ years)**
- ☐ **Married (_____ years)**
- ☐ **Separated (_____ years)**
- ☐ **Widowed (_____ years)**

EMPLOYMENT STATUS

Are you employed? Yes ☐ No ☐

Employer Name: _____

Years with Employer: _____

Are you using EAP? Yes ☐ No ☐

Job Title: _____

Stress level of this position: ☐ Low ☐ Med ☐ High

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

Phone (Home): ( )_____ **Phone (Cell):** ( )_____

Relationship to you: _____

RERERENT

By whom were you referred or how did you learn of our organization and services?

_____

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem you are experiencing: _____

_____

_____

_____

Please check all of the behaviours and symptoms that you consider problematic:

☐ Distractibility	☐ Loss of pleasure/interest	☐ Guilt/shame
☐ Hyperactivity	☐ Hopelessness	☐ Fatigue
☐ Impulsivity	☐ Thoughts of death	☐ Change in appetite
☐ Boredom	☐ Self-harm behaviours	☐ Lack of motivation
☐ Poor memory/confusion	☐ Crying spells	☐ Withdrawal from people
☐ Seasonal mood changes	☐ Loneliness	☐ Anxiety/worry
☐ Sadness/depression	☐ Low self-worth	☐ Panic attacks

- ☐ Fear away from home
- ☐ Compulsive behaviour
- ☐ Homicidal thoughts
- ☐ Visual hallucinations
- ☐ Excessive energy
- ☐ Nightmares
- ☐ Computer addiction
- ☐ Sexual problems
- ☐ Alcohol/drug use
- ☐ Social discomfort
- ☐ Aggression/fights
- ☐ Flashbacks
- ☐ Suspicion/paranoia
- ☐ Wide mood swings
- ☐ Eating problems
- ☐ Problems with pornography
- ☐ Relationship problems
- ☐ Recurring, disturbing memories
- ☐ Obsessive thoughts
- ☐ Irritability/anger
- ☐ Hearing voices
- ☐ Racing thoughts
- ☐ Sleep problems
- ☐ Gambling problems
- ☐ Parenting problems
- ☐ Work/school problems
- ☐ Other: _____

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational Activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

Yes ☐ No ☐ Have you ever had thoughts, made statements or attempted to hurt yourself? If yes, please describe: _____

_____

_____

Yes ☐ No ☐ Have you ever had thoughts, made statements or attempted to hurt someone else? If yes, please describe: _____

_____

_____

Yes ☐ No ☐ Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

_____

_____

Yes ☐ No ☐ Have you gambled in the past 6 months? If so, please indicate below:

Yes ☐ No ☐ Have you ever felt the need to bet more and more money?

Yes ☐ No ☐ Have you ever had to lie to people important to you about how much you gambled?

FAMILY AND DEVELOPMENTAL HISTORY

RELATIONSHIP	NAME	AGE	QUALITY OF RELATIONSHIP
Mother			
Father			
Step-Mother			
Step-Father			
Siblings			
Spouse/partner			
Children			

FAMILY MENTAL HEALTH PROBLEMS	WHO?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Other:	

Please check if you have experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Violence in the home
- ☐ Parent substance abuse
- ☐ Place a child for adoption
- ☐ Crime Victim
- ☐ Lived in a foster home
- ☐ Multiple family moves
- ☐ Loss of a loved one
- ☐ Workplace violence
- ☐ Other trauma experience:

_____

- ☐ Neglect
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Neglect
- ☐ Parent illness
- ☐ Homelessness
- ☐ Financial issues
- ☐ Teen pregnancy
- ☐ Military Service

PREVIOUS MENTAL HEALTH TREATMENT

YES	NO	TREATMENT TYPE	WHEN?	PROVIDER/ PROGRAM	REASON FOR TREATMENT
☐	☐	Outpatient Counselling			
☐	☐	Medication (mental health)			
☐	☐	Psychiatric Hospitalization			
☐	☐	Drug/Alcohol Treatment			
☐	☐	Self-help/Support Groups			

MEDICAL INFORMATION

Have you experienced any of the following medical conditions during your lifetime?

- ☐ Allergies
- ☐ Chronic pain
- ☐ Dizziness/fainting
- ☐ High fevers
- ☐ Sexually transmitted disease
- ☐ Asthma
- ☐ Surgery
- ☐ Meningitis
- ☐ Diabetes
- ☐ Abortion
- ☐ Headaches
- ☐ Serious accident
- ☐ Seizures
- ☐ Hearing problems
- ☐ Sleep disorder
- ☐ Stomach aches
- ☐ Head injury
- ☐ Vision problems
- ☐ Miscarriage
- ☐ Other: _____

Please list any CURRENT health concerns: _____

_____

Please list any current prescription medications: ☐ None

_____

_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network *(Check all that apply)*:

- ☐ Family
- ☐ Neighbours
- ☐ Friends
- ☐ Students
- ☐ Support/Self-help Group
- ☐ Co-workers
- ☐ Community Group
- ☐ Religious/Spiritual Centre

To which cultural or ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

_____

How important are spiritual matters to you? Not at all ☐ Little ☐ Somewhat ☐ Very Much ☐

Please describe your strengths, skills and talents: _____

Describe any special areas of interest or hobbies (ie. books, physical fitness, etc.): _____

_____

EDUCATION

Are you currently attending school? ☐ Yes ☐ No

☐ High School Graduate	OR	☐ GED	Year _____
☐ College Diploma	Year _____		Major area of study _____
☐ Undergraduate Degree	Year _____		Major area of study _____
☐ Graduate Degree	Year _____		Major area of study _____

MILITARY SERVICE

Have you been/are you currently in the military? Yes ☐ No ☐ *(*If no, skip this section)*

Branch: _____

Date of Discharge: _____

Type of Discharge: _____

Rank: _____

Were you in combat? ☐ Yes ☐ No

LEGAL

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain:

_____

_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain: _____

_____

INFORMED CONSENT – TERMS OF SERVICE AGREEMENT

In addition to, and in conjunction with, our Corporate Terms of Service, the following terms and conditions constitute the user's informed consent and agreement with the following terms of this Service Agreement:

1. The client will be charged the established rate fee for 1.0 hour of on-line counselling services for the date and time specified. Clients who attend their appointment late will forfeit any time lost due to their tardiness and the scheduled appointment will end at the original time specified in the appointment booking, at the original rate. Please note that clients who are in excess of 15 minutes late for their confirmed scheduled appointment will forfeit their entire appointment and be subject to the CANCELLATION/NO SHOW policy.
2. Clients who do not provide sufficient notice of cancellation or provide no notice of cancellation for their confirmed on-line appointments will be charged a fee of $100.00 dollars for their missed appointment. Please note that clients who continue to miss appointments without sufficient notice will be subject to our refusal of services, as per our Terms of Service, at our discretion.
3. As per Provincial and Federal Licensing requirements, counselling services are available to Canadian citizens only who reside in Provincial territories where the therapist is duly authorized to practice. These Provinces currently consist of: Alberta, British Columbia. We regret that we are unable to provide professional counselling services to anyone outside of these geographical regions.
4. The client acknowledges and accepts the Terms and Conditions and has been provided sufficient opportunity to review IMPRESSIONS FCS INC. corporate Terms of Service via our on-line website and acknowledges their full acceptance and compliance with all terms and conditions represented. The client further acknowledges and accepts they have been provided with satisfactory responses to their submitted enquries and holds IMPRESSIONS FCS INC. harmless for any miscommunications, misunderstandings or lack of sufficient and accurate information beyond the control and influence of IMPRESSIONS FCS INC.

CONSENTS/AUTHORIZATIONS

PLEASE INITIAL

Informed Consent
I have read and fully understand the Terms of Service as provided to me by IMPRESSIONS FCS INC. I consent to receiving mental health counselling services with IMPRESSIONS FCS INC. and am satisfied my questions regarding these services have been answered to my full understanding and acceptance.

Terms of Service - Rights & Responsibilities
I have reviewed and understand my rights and responsibilities for receiving counselling services with IMPRESSIONS FCS INC. This includes complaints, fees, no-show/cancellation policies and my rights. A copy of these rights and responsibilities are available to me on the IMPRESSIONS website. All questions have been answered to my satisfaction.

Notice of Privacy Practices
I have reviewed IMPRESSIONS FCS INC. privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have access to a copy of these policies via the IMPRESSIONS website. I understand that IMPRESSIONS FCS INC. will share basic information with my primary care provider unless I ask to "restrict" this disclosure.

Financial
I have reviewed and understand my responsibility to provide payment for services received, at the conclusion of each counselling session, for the amount indicated. If I cancel a scheduled appointment without providing 24 hours advance notice, or do not show up for a scheduled on-line appointment, I will be invoiced $100 dollars. I am the "financial guarantor", meaning I will be responsible for all payments invoiced for services and accept a 3% monthly late-payment fee for all outstanding balances beyond 7 days from the original service date.

Video/Audio Recording
I understand and accept the purposes for mandatory video/audio recording of all counselling sessions as a measure of clinical evaluative processes in maximizing my therapist's ability to review and assess my treatment outcomes. I provide my authorized consent for video/audio recording of my counselling sessions and understand I may revoke this consent, in writing, at any time. I understand and accept that IMPRESSIONS FCS INC. reserves the right to refuse services if my consent to video/audio record my counselling sessions is revoked.

CLIENT NAME: _____ **CLIENT BIRTHDATE:** _____

If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other _____

Parent/Guardian Signature: _____ *By signing your name here, you consent to your youth receiving counselling services.*

CLIENT SIGNATURE: _____ SIGN HERE **DATE:** _____

THERAPIST NOTES: _____

_____

_____

_____

_____

_____

_____

CASEFILE STATUS: ☐ **Urgent/Emergency** ☐ **Regular** **Referral Source:** _____

RECOMMENDATIONS RESULTING FROM INTAKE: _____

_____