The Counselling Corner

Saskatchewan Offices

www.thecounsellingcorner.ca
306-270-4178

CHILD THERAPY INTAKE FORM

Please complete on behalf of your child

Name of person completing this form:_____
Your relationship to the child:_____
Phone:_____ Email:_____

Name of other parent/legal guardian:_____
Phone:_____Email:_____

Child's first name:_____ Last name:_____
Age:_____ Date of Birth:_____
Home Address:_____
Who does the child live with:_____

Parents are currently: __Married __Separated __Divorced __Common-Law __ Other

ACADEMIC INFORMATION:
Name of child's school:_____ Grade:_____

THE REASON FOR YOUR CHILD'S VISIT:

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY:
Has your child been diagnosed with any conditions:_____
_____
_____

Please list **any medications your child currently** takes:_____
_____

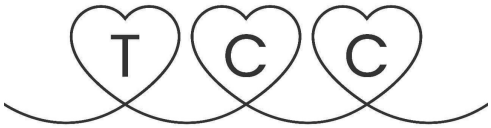
Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment). _____
_____
_____
_____
_____
_____
_____

Please list any family history of mental illness:_____
_____
_____
_____
_____

What are your goals for counselling:_____
_____
_____
_____
_____

SYMPTOMS LIST PLEASE CHECK ALL THAT APPLY:
*Parents, if possible, please allow your child to complete this form. If your child is too young, complete symptom check list from your observations of your child.

Headaches___ Memory problems___ Depression Sleep problems___
Heart palpitations___ Feeling tense or nervous___ Academic concerns___
Ideas of harming yourself___ Drug use___ Worries about money___
Feeling shy around others___ Not confident___ Having a lack of friends___
Stomach problems___ Concerned about eating habits___
Feelings of panic, fear, phobias___ Trouble concentrating___ Alcohol use___
Feeling sad or depressed___ Grief or loss___ Nightmares___
Feeling restless___ Feelings of hopelessness___ Feelings of worthlessness___
Low self-esteem___ Disturbing thoughts___ Hallucinations___ Aggression___
Mood swings___ Recurring thoughts___ Chest pain___ Suicidal thoughts___
Trembling___ Sexual concerns___ Sexual identity concerns___ Anger___
Ideas of harming others___ Memory problems___ Chronic pain___
Blaming or criticizing self___ Abusing others___ Dizziness___ Feeling tired___
Feeling a need to be on the go___ Problems at home___ Anxiety___
Antisocial or illegal behavior___ Concerned about family members___
Irritability___ Abused by others___ Sick often___ Isolating self___
Disorganized thoughts___ Relationship problems___ Distractability___ Impulsive___
Poor judgment___



Please add any other information about your child that would be helpful for the counselor to know:_____
_____
_____
_____
_____
_____
_____

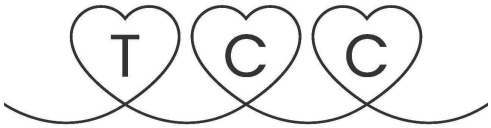
AGREEMENT FOR PARENTS OF MINOR CHILDREN

Counselling can be a very important resource for children. Establishing a therapeutic alliance outside of the home can:

- Facilitate open and appropriate expression of strong feelings such as guilt, grief, sadness and anger.
- Provide an emotionally neutral setting in which children can explore these feelings.
- Help children understand, accept, and cope with whatever difficulty they may be experiencing.
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

However, the usefulness of therapy may be limited when the therapy itself becomes simply another matter of dispute between parent and child or between parents. With this in mind, and in order to best help your child, I strongly recommend that your child and each of the child's caregivers (e.g., parents or stepparents) mutually accept the following as requisites to participation in therapy.

1. As your child's counsellor, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.
2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child's therapist.
3. I ask that caregivers recognize and, as necessary, reaffirm to the child, that I am the child's helper. This may include encouragement for the child that is reluctant or anxious about therapy, or support and optimism regarding change. Also, I have found that use of therapy as a consequence or punishment is usually not helpful.
4. This counselling **Will Not** yield recommendations about custody, nor do I provide reports.



CLIENT (Parent)/THERAPIST AGREEMENT FOR PROVISION OF COUNSELLING SERVICES BETWEEN:

_____(the "Client") and _____(the "Therapist")

The Client/Parent agrees:

1. To provide prior notice of 24 hours if canceling an appointment. (Voicemail can be left anytime) Failure to provide proper notice may result in a personal charge for the late cancellation. Your prompt cancellation will permit someone else to the time and thus reduce the waiting periods for others;

2. To pay the Therapist's fees at end of each session. If you are using an Employee Assistance Plan or 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 Employee Assistance Plan or Insurance Policy. Neither the therapist nor The Counselling Corner is responsible for denied claims.

3. If you subpoena your therapist or anyone from The Counselling Corner, costs for court preparation, client rescheduling and court appearance(s) will be paid by the client/parent at a rate of $180 per hour.

The Therapist agrees:

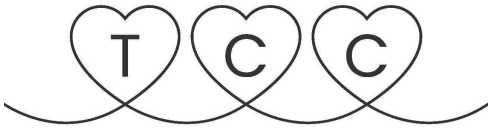
1. To provide counselling assistance based upon the Client's/Parent's goals.

2. To maintain the confidentiality of the Client, unless:

a) He/she 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,
I confirm that I have read and understand the terms set out above and that I agree to these terms. I also agree that this contract for the Provision of Counselling Services is between the Therapist listed below and myself. I also understand that my file will be destroyed within seven (7) years of my last visit.

Client's Full Name:
(Print please) _____

Address _____Phone_____

REQUIRES BOTH PARENT'S REGARDLESS OF MARITAL STATUS WHEN CHILD IS 15 YEARS OF AGE AND YOUNGER

Parent's Signature:_____Date:_____

Parent's Signature:_____ Date:_____

Therapist:(Print please)_____

Therapist's Signature:_____Date :_____

Custody arrangements : Joint___ Sole___ None___

*****Custody Agreement papers required (if parents had these drawn up with legal representation):**
- when parents are separated/divorced and client is 15 years old or under and one parent is claiming sole custody.***

If separated or divorced I still require both parents' signatures unless when you provide me with a copy of the custody agreement and **it states sole custody. Primary residence still requires both parent's signatures.**

Counselling Costs will be paid personally by a parent at the time of each session and submitted by the parent to their own Insurance Provider or Employee Assistance Program.
Parent's Signature _____Date_____

FOR THOSE REQUESTING FEE REIMBURSEMENT FROM AN INSURANCE PROVIDER
While I understand that some Counsellors', Social Workers', 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 The Counselling Corner 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 my Therapist or The Counselling Corner,

Parent's Signature _____ Date _____

FOR THOSE WHOSE PARENT(S) WILL BE PAYING FOR YOUR SESSIONS
For the purpose of account payment, authorization is given to release length and date of session only. The therapist is not authorized to release any other information, except in accordance with law.

Parent's Signature_____Date _____