Insight Counselling Services

CLIENT INFORMATION FORM

Welcome. Please fill in the following information on both sides of this sheet. Please print. This information is strictly confidential. If you have any questions, feel free to ask your counsellor as to how to fill it in. Thank you.

PERSONAL AND CONTACT INFORMATION:

Family Name		Your First Name:	Spouse's Name (if couples counselling)
Your DOB (date of birth)	Spouse DOB	Your Cell Number:	Spouse's Cell Number (if couples counselling)

Street Address	City (if not Medicine Hat)	Postal Code

Home Phone	Employment Status □ Full time □ Part time □ Unemployed □ Not in Labour Force □ N/A	Employer Company Name	Years with Employer

May we contact you, if necessary: At Home? □ Yes □ No Cell? □ Yes □ No Cell Text? □ Yes □ No Email? □ Yes □ No	Did someone refer you? If so, who?

What is your and your spouse's level of education?

Name:_____ - □ Elementary □ Some High School □ Completed High School □ Some College/University □ Completed College/University

Name:_____ - □ Elementary □ Some High School □ Completed High School □ Some College/University □ Completed College/University

FAMILY INFORMATION:

Current Marital Status
□ Single never married □ Married □ Separated □ Divorced
□ Common law or long-term relationship □ Widow/Widower

Date (month, day, year) Married or Common Law

What is your household composition?
□ I live alone □ Live with family □ Live with other relatives
□ Live with non-related person □ Other

Religious Background: | Current Religious Affiliation:

Names of all your children	Sex	Age

In case of an emergency situation, who may we contact?

Name: _____ Phone: _____ Relationship: _____

Have you ever had counselling before? □ Yes □ No If yes, how would you rate your experience? □ Negative □ Alright □ Positive □ Excellent

MEDICAL INFORMATION:

Any health problems?
□ Yes
□ No

If yes, what are they? For You? For your spouse?

Are you taking any medications? □Yes □ No Please list all Medications you are taking:

Who?	Medication	Reason for Medication	Dosage	Doctor who prescribed
□ You □ Spouse				
□ You □ Spouse				
□ You □ Spouse				
□ You □ Spouse				
□ You □ Spouse				

CONCERNS AND ISSUES:

Please check all that are of concern to you at this time:

□ Relationship issues	□ Parent/child conflict	□ Parenting Issues
□ Family problems	□ Work/school problems or stress	□ Money problems
□ Mental health issue or concern	□ Loss and grief issues	□ Relationship abuse or violence
□ Your own substance usage	□ Someone else's substance usage	□ Legal problems
□ Medical problems	□ Adult survivor of child abuse	□ Criminal justice involvement
□ Low self-esteem	□ Feeling depressed	□ Thoughts of suicide
□ Feeling anxious	□ Gambling issues	□ Other: _____

CONFIDENTIALITY:

Each person, couple, or family coming for counselling can expect that what they communicate will be kept strictly confidential. Under the law, your counsellor is not allowed to release any information about you except in the following high risk situations. Examples are:

1. If there is a risk of you harming yourself in a life threatening way
2. If there is a risk of someone else's life being at risk
3. If you tell us of a child being harmed or abused (who is still a child)
4. If your file has been subpoenaed by a federal or provincial court

If any of the above situations arise, it is our commitment to always make you informed prior to release of information and give you options as to how the information may be released.

Other than the above, it is our commitment to request your permission before speaking to anyone regarding you. We would then request your consent through a "release of information" form.

If you have questions about the implications of this policy, please ask your counsellor before disclosing such info.

FEES and REQUEST OF SERVICE:

Counselling sessions are $130 per 1.25-hour session (75 min). Counselling sessions longer than 1.25 hours are paid at $104/hr (which is the same rate). Payment may be made by cash, PayPal, E-Transfer, cheque or credit card at the end of each session. I understand I am responsible for payment of a session <u>not</u> cancelled in advance. There are no refunds or exchanges.

I/We, _____, having read and understood the above policies regarding CONFIDENTIALITY and FEES, accept and agree to these conditions of confidentiality and to receiving counselling services through Insight Counselling Services.

Signature(s): _____ Date: _____

(OPTIONAL) CREDIT CARD AUTHORIZATION:

I, _____, authorize billing my credit card below for each session

□ for me, □ for my spouse, □ for: _____ (Only check what applies).

Type of card: □ Visa □ Master Card □ American Express □ Discover Card

Card Number: _____ Expiry Date: _____

Signature of Card Owner: _____ Today's Date: _____

(Please note that this authorization can be revoked at any time by informing your counsellor. Thank you.)

EMAIL ADDRESS FOR RECEIPTS:

My Email address is: