The COUNSELLING CORNER

Offices across Saskatchewan

www.thecounsellingcorner.ca | 306-270-4178

CHILD THERAPY INTAKE FORM

Please complete it on behalf of your child.

Name of person completing this form:_____

Your relationship with the child:_____

Phone:_____ Email:_____

Name of other parent/legal guardian:_____

Phone:_____ Email:_____

Child's first and last name:_____

Age:_____ Date of birth:_____

Home address:_____

Who does the child live with:_____

Parents are currently: ▢ Married | ▢ Separated | ▢ Divorced | ▢ Common-Law

▢ Other (Please specify):_____

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 **(, type of professionals, reason for the consultation, nature of the allotment, outcome of the treatment):**

_____

_____

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_____

Please list any family history of mental illness:

_____

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What are your goals for counselling?:

_____

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_____

Symptoms list (Please check all that apply):
*Parents, if possible, please allow your child to complete this question. If your child is too young, complete this checklist from the 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 | ▢ Chronic pain | ▢ Blaming or criticising self |

▢ Abusing others | ▢ Dizziness | ▢ Feeling tired |

▢ Feeling a need to be on the go | ▢ Problems at home | ▢ Anxiety |

▢ Antisocial or illegal behaviour | ▢ Concerned about family members | ▢ Irritability |

▢ Abused by others | ▢ Sick often | ▢ isolating self | ▢ Disorganized thoughts |

▢ Relationship problems | ▢ Distractibility | ▢ Impulsive | ▢ Poor judgement |

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

_____

_____

_____

_____

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_____

AGREEMENT FOR PARENTS OF MINOR CHILDREN:

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

- 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 step parents) 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., paediatrician, 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 behaviour 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 of cancelling an appointment. (Voicemail can be leff 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 lime and thus reduce the waiting periods for others;

2. To pay the Therapist's fees at the 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 Counseling Corner is responsible for denied claims

3. If you subpoena your therapist or anyone from The Counseling 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 aid 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.

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 om responsible for paying the Therapist's fee of the time of each session and submitting my claim personally,
- Neither the Therapist nor The Counseling 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 Counseling 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 authorised to release any other information, except in accordance with law.

Parent's Signature: _____ Date: _____

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 (printed): _____

Address: _____ Phone: _____

REQUIRES BOTH PARENT'S REGARDLESS OF MARITAL STATUS WHEN CHILD IS 17 YEARS OF AGE AND YOUNGER

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Therapist's name (printed): _____

Therapist's Signature: _____ Date: _____

Custody agreements: ▢ Joint | ▢ Sole | ▢ None

*__Custody Agreement papers required (if parents had these drawn up with legal representation):__

***When parents are separated/divorced and the client is 17 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.**

Client Email/Phone/Texting Consent Portion

This form provides information about the risks of these forms of communication, guidelines for email/phone/text communication, and how we use email/phone/text communication. It also will be used to document the consent between the mental health professional and the client for communication methods such as but not limited to email, phone, and text messages (also known as SMS).

I, [Client's Name] _____, hereby consent to engage in therapy services with [mental health professional's Name] _____ (hereinafter referred to as "Mental health professional"). I understand that in addition to traditional in-person sessions, the mental health professional may offer communication via electronic means such as email, phone, texting (also known as SMS), and voicemail. I acknowledge that the use of electronic communication introduces certain risks, and I agree to the following terms and conditions:

Purpose: I understand that the purpose of electronic communication in therapy is to facilitate scheduling, discuss administrative matters, and engage in brief check-ins or therapeutic support between sessions. It is not intended to replace face-to-face therapy sessions in the context of this agreement.

Risks: I understand that electronic communication may not be entirely secure and could be intercepted, forwarded, or stored in systems beyond the control of the mental health professional. While the mental health professional will take reasonable measures to ensure the confidentiality of our communication, I acknowledge that there are inherent risks to electronic communication such as but not limited to:

> **A**: Emails, phone calls/voicemails, and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
>
> **B**: Email and text senders can easily mistype the email address or phone number and send the information to an undesired recipient.

C: Backup copies of emails, text messages, and voicemails may even exist even after the client and or the mental health professional has deleted their copy

D: Employers, online service providers, telecommunications providers may have a right to inspect information sent through their systems

E: Emails, phone calls, voicemails, text messages can be intercepted, altered, forwarded, or used without authorization or detection

F: Emails, voicemails, and text messages can be used in a court of law.

G: Emails, phone calls, voicemails, and text messages may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Emergency Situations: I understand that electronic communication may not be an appropriate means of communication during emergencies or crisis situations. In the event of an emergency, I agree to contact emergency services @ 911 or the appropriate crisis hotline.

Response Time: I acknowledge that the mental health professional may not be able to respond immediately to electronic communication and that response times may vary depending on the nature of the communication and the mental health professional's availability.

Limits of Confidentiality: I understand that the same confidentiality and privacy standards apply to electronic communication as to in-person sessions. However, I acknowledge that there are limitations to confidentiality, such as the potential for unauthorised access to electronic communications. The mental health professional accepts no liability for unintentional disclosure of confidential client information.

Communication Boundaries: I agree to use electronic communication responsibly and respect boundaries around the frequency and content of communication. I understand that the mental health professional may establish guidelines for electronic communication to ensure that it remains therapeutic in nature.

Documentation: I understand that electronic communication may be documented as part of my therapy record. I agree with the mental health professional's documentation policies regarding electronic communication.

Consent Revocation: I understand that I have the right to revoke this consent for electronic communication at any time. If I choose to revoke consent, I will notify the mental health professional in writing and understand that future communication will be limited to in-person sessions or other agreed-upon means.

By signing below, I acknowledge that I have read and understood the terms of this consent for electronic communication in therapy services, and I agree to abide by them.

Client's Name: _____

Client's Signature: _____

Date: _____

Mental health professional's Name: _____

Mental health professional's Signature: _____

Date: _____