MuscleElements
Health & Wellness

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PSYCHOLOGY CLIENT INTAKE FORM

Today's Date:

Last Name:	First Name:	Circle: Mr. Ms. Mrs Dr.

Birth date: DD - MM - YYYY	Age:	Circle # of preferred contact:

Address:	Phone (home):
City: Province: Postal Code:	Phone (work):
Email:	Phone (cell):

Family Physician name:	Family Physician phone:

CLIENT HISTORY

Referred by: _____

What are the main reasons you are seeking help at this time?

_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____

How would you describe your current motivation to seek support and/or make changes?

Poor Unsatisfactory Satisfactory Good Very Good

Please explain: _____
_____
_____

Previous therapy/mental health services:

_____
_____

Current Medications:

_____
_____
_____

Medical Diagnoses and/or disabilities:

_____

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____
_____

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please describe: _____

History of hospitalizations, surgeries, dental surgeries, labour: _____
_____
_____

How many times per week do you generally exercise? What and how long? _____
_____

How would you rate your current eating habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please describe: _____

Have you ever had a problem with disordered eating? If yes, please circle:

Anorexia Bulimia Binging Overeating

Are you currently experiencing overwhelming sadness, grief, or depression? If yes, for how long? _____
_____

Are you currently experiencing chronic pain? If yes, please describe: _____
_____

Do you consume drugs? If yes, what, how often and how much? _____
_____

Do you consume alcohol? If yes, how often and how much? _____
_____

Do you have a spiritual practice? If so, please describe: _____
_____

Are you currently in a romantic relationship? If yes, for how long? _____

What significant life changes or stressful events have you experienced recently? _____
_____
_____

Are you currently employed? If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____
_____

FAMILY HISTORY
(Please Circle) (Family Member)

Alcohol/Substance Abuse _____
Anxiety _____
Depression _____
Domestic Violence _____
Eating Disorders _____
Obesity _____
Obsessive Compulsive Behaviour _____
Schizophrenia _____
Suicide Attempts _____

SUPPORTS

What do you consider to be some of your strengths? _____
_____
_____

What do you do that makes you feel good? How do you reduce your stress? _____
_____
_____

Who/what are your best supports (family, friends, pets, church, etc)? _____
_____
_____

ABOUT YOUR THERAPIST

Kelley Mitchell has a Bachelor of Education with a minor in Educational Psychology and a Masters of Educational Psychology with specialization in School Counselling from the University of Alberta. I have completed two years of training in Hakomi Therapy and I am supervised by a Certified Hakomi Therapist. I am a Registered Psychologist in good standing with the College of Alberta Psychologists and a member in good standing of the Psychologists' Association of Alberta. I am also an employee of Elk Island Public Schools and work as a Registered Psychologist at Ardrossan Elementary School.

THERAPEUTIC APPROACH

I integrate aspects of evidence-based cognitive therapy with body-centred, experiential, mindfulness-based approaches like Hakomi. I believe therapy is a collaborative process designed to support an individual's self-study. This process works best if you are able to:

1) follow and report on your present experience
2) focus inward and notice your reactions
3) allow the experience and expression of some painful feelings
4) have the courage to be open and honest about your experience

RISKS AND BENEFITS OF THERAPY

There are benefits and risks to engaging in any form of counselling or psychotherapy. The potential risks are considered to be relatively few, but may include the following:

You may experience uncomfortable feelings, such as sadness, guilt, fear, anxiety, frustration, anger, or loneliness, because the process of therapy often explores areas you may feel stuck or limited. You may find yourself recalling unpleasant memories either during or in between sessions, which is a normal part of the therapy process. Your relationships with the people closest to you may begin to change, as you begin to learn more about yourself and find new ways of coping and problem solving. You may find therapy is simply not a good fit for you.

Despite these risks, therapy has generally been shown to benefit those who choose to engage in it. Therapy has potential for gaining clarity, accessing strengths, reducing distress and enhancing relationships. Therapy will require active effort on your part, both within and outside of sessions, to maximize benefit. Please feel free to bring up questions or concerns you may have at any time during the therapy process so that we can discuss them. In the case that we decide it would be best not to continue working together, I will be glad to explore other options with you, such as a referral to another mental health professional who might be more suitable to address your individual needs.

CONFIDENTIALITY

Personal information collected from clients is used a) maintain clients file, b) to bill clients for services rendered, and c) to collect unpaid monies.

As a Registered Psychologist, I adhere to the College of Alberta Psychologists Code of Ethics. Your personal information is confidential, and no information will be released without your knowledge and written consent with respect to the following exceptions:

1. As a student of the Hakomi therapy method, I am supervised by a Certified Hakomi Therapist. As part of my supervision and training, I consult with her on a regular basis. All supervision sessions maintain client confidentiality as outlined above.
2. All professionals are required by law to report to the police or Child Services authorities any information about suspected or potential abuse and neglect of children.
3. Confidentiality may be waived based on clinical judgment that a client is in serious risk of harming him/herself or others in the community.
4. Any information obtained in treatment may be subpoenaed in a court of law.

COLLABORATION

Working as part of a multi-disciplinary team at Muscle Elements, it may be beneficial for practitioners to discuss treatment plans for shared clients. If this may benefit a client, a release of information would need to be signed by you before any confidential information is shared.

FEES

Fees for therapy are set according to credentials and by professional fee guidelines. Therapy fees are $160 per hour. Payment is due at each session except for employee assistance programs or other 3rd party arrangements. All or partial fees may be recovered through health insurance plans. Fees may also be tax deductible under medical expenses on your income tax.

CANCELLATION OF APPOINTMENTS

Cancellation of appointments is required at least 24 hours in advance. This time frame allows for appointments to be offered to other clients. Appointments that are not cancelled or kept will incur a charge as outlined below.

We require at least 24 hours notice to reschedule or cancel a session without incurring any fees. This policy is in place to allow us to offer the allocated time to another client who may be on a cancellation list for an appointment. It is possible to cancel appointments through our online booking system up to 24 hours before the appointment. The full session fee will be charged for a missed appointment or less than 24 hours cancellation of a session. Your credit card will be charged at the time of the missed appointment.

We understand that sometimes you may be unable to keep an appointment because of sudden illness or an unexpected personal emergency. If this happens to you, please contact us as soon as possible to explain the situation and the fee may be reduced or waived.

SIGNATURES

I, _____, have read and agree to the above cancellation policy, and authorize Muscle Elements Health & Wellness to use my credit card for payment of $160.00 in the event of a cancellation or missed appointment as described above.

_____ _____
Signature Today's Date

_____ _____
Credit Card Number (Visa/MC/AMEX) Expiration Date

I understand that services are being sought for _____ (print client name) for the purposes of therapy and not for litigation/court purposes. I have read and understand the contents of this Client Services Contract and consent to services for this person.

Client (or parent/guardian)'s Signature:_____ Date:_____

Client (or parent/guardian)'s Signature:_____ Date:_____

Therapist's Signature: _____ Date:_____

Copies of this contract are available upon request