Welcome to my practice. I hope the experience is a positive one for you. To get the most out of counseling, I want to give you some quick tips about what to expect:

1. You'll need to fill out this intake packet first. Fill out the information sheet, read the consent form carefully and if you are coming for couples counseling, please sign and have your partner sign the marriage and relationship consent form. Bring any questions that you might have into our first session.

2. The credit card payment consent form is attached for your convenience, as well as to ensure against late cancellations and no shows. As I accept debit and credit cards, this option makes it convenient for many clients to pay for their sessions this way, and takes the hassle out of it. I charge for each session after each session is completed, and will charge your card if you late cancel or no show. You can also pay with cash or check if you choose.

3. Prior to our session, you may want to write some ideas about the things that you are struggling with and bring those into our first session. Sometimes clients like to put to paper the things that they want to work on. We'll create a treatment plan that includes those goals to work on in our first session.

4. Our first session is an intake session. Although we will be talking about and highlighting the problems that brought you into counseling, it is not a formal counseling session. Usually, our second session begins the counseling process.

5. My office is in the Birch Wellness Center at 34 Carlton St. There is usually parking available on Carlton Street, or around the corner on Assiniboine. If there isn't parking available on the street, there is a parking lot at the corner of Edmonton and Broadway (one block from Carlton St.). There is a sign in front. Please check in at the reception desk and inform them that you have an appointment with Kevin.

6. If you have an evening session after 5:00 PM, be aware that the front office staff will not be there to greet you. Please have a seat in the waiting room and I will come and get you after my next session.

7. I look forward to working with you in our counseling sessions together, and please let me know if there is anything I can do to make your experience here in counseling better for you. Congratulations on making the step to get some help.

Kevin Richardson MSW, RSW

Psychotherapist

Client Information and Intake Form

Demographic/Contact Information Date: _____

Full Name:_____ Age: _____

Birth Date: _____ Gender: Male □ Female □

Address: Street: _____City: _____

Province: _____ Postal Code: _____

Email Address: _____

Email is a quick and convenient and used by many clients. However, while every effort is made to safeguard your privacy, we cannot fully guarantee the confidentiality of email messages over the Internet. If you do not want to communicate via email please let us know.

Phone: Home _____ May a message be left? Yes □ No □

Work _____ May messages be left? Yes □ No □

Cell _____ May messages be left? Yes □ No □

Emergency Contact: _____ Phone:_____

Relationship to You:_____

Referral Source (Please indicate website, if applicable):_____

PRIMARY CONCERN

Check only those that apply. If you check more than one, please select your top three and rank them from highest to lowest in terms of the priority you place on resolving them

(1=highest priority, 2=second highest, 3=third highest).

(√) (Check all that apply)	Rank	(√) (Check all that apply)	Rank
___ Depressed Mood	_____	___ Parent-Adult Child Relations	_____
___ Anxiety	_____	___ Blended Family Issues	_____
___ Anger Management	_____	___ Family Conflict	_____
___ Self-Esteem or Confidence	_____	___ Work problems	_____
___ Social Difficulties	_____	___ Education/ Career Concerns	_____
___ Stress Management	_____	___ Financial Concerns	_____
___ Bereavement/ Loss	_____	___ Legal Concerns	_____
___ Domestic Violence or Abuse (Current)	_____	___ Medical Issues	_____
___ Premarital Counselling	_____	___ Substance Abuse (Alcohol/Drugs)	_____
___ Communication Problems/Relationship Conflict	_____	___ Gambling Difficulties	_____
___ Sexual Intimacy Concerns	_____	___ Other Addictions (i.e. Sex, Shopping)	_____
___ Emotional or Sexual Infidelity/affairs	_____	___ Eating Disorder	_____
___ Other Marital/Relationship Concerns	_____	___ Weight Management / Body Image	_____
___ Separation / Divorce / Break-Up	_____	___ Spiritual Problems	_____
___ Custody Concerns	_____	___ Child – Behavioral Problems	_____
___ Parenting	_____	___ Child – Mood / Anxiety Problems	_____
		___ Child – Academic Problems	_____
		___ Child – Social/ Relational Problems	_____
		___ Other _____	

Please describe the main difficulty that brought you to see me:

_____

_____

_____

When and how did the concern begin?

_____

_____

How have you tried to resolve this concern thus far? What has proved beneficial and what has not helped?

_____

_____

_____

Abuse history: ❑ I was not abused in any way. ❑ I was abused.

Effects on You:

_____

_____

_____

LIFESTYLE BEHAVIOURS

Do you **Exercise**? □ Yes □ No If yes, what do you do? _____

Do you drink **alcohol**? □ Yes □ No If yes, how many drink per week: _____

Do you drink **coffee/ tea?** □ Yes □ No If yes, please estimate quantity per day: _____

Do you **smoke** tobacco? □ Yes □ No If yes, please estimate quantity per day: _____

Do you use any **illicit drugs**? □ Yes □ No If yes, please specify: _____

If you drink alcohol or use illicit drugs, please answer the following questions:

Have you ever thought you should **Cut down** on your drinking/ drug use? □ Yes □ NoHave you ever felt bad or **Guilty** about your drinking/ drug use? □ Yes □ No

Have you ever had a drink / used drugs in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover? □ Yes □ No

Have people **Annoyed** you by criticizing your drinking/ drug use? □ Yes □ No

BIOGRAPHICAL INFORMATION (circle)

Relationship Status: □ Single □ Never married □ Exclusive dating □ Cohabiting □ Married □ Remarried □ Separated □ Divorced □ Widowed

Do you have children? If so, please list their ages, names, and with whom living
_____

_____

Any financial and/or legal problems:_____

Education: *(highest level)*	Income: *(household annual)*
□ Some high school □ High school □ Technical / Trades □ 2-year associate degree □ Some undergraduate college or university □ Undergraduate degree □ Some graduate level □ Graduate degree: _____	□ $0-30,000 □ $31-60K □ $61-90K □ $91-120K □$120-150K □ $150K + Current Occupation: _____ Years at Current Job: _____Hrs per week: _____ Do you enjoy your work? □ A lot □ Moderately □ Very little Career Goals: _____

Please also describe any work stressors:
_____

_____

MEDICAL INFORMATION

Primary Care Physician/GP: _____ Phone: _____

Date of Last Physical Exam: _____ Findings from that Exam: _____

_____

Current medical conditions (e.g., diabetes, hypertension, heart problems, asthma, head trauma, cancer, etc.)

_____

_____

MEDICATION

Please list current medications, dosage, and prescribing physician:

_____

_____

Have you been previously prescribed psychiatric medications? Yes☐ No☐

If yes, what medication, dosage, dates began/ended?

_____

_____

Previous Psychotherapy/ Drug/Alcohol Treatment, Mental Health Hospitalization

Have you had previous psychotherapy/counseling, drug or alcohol treatment? Yes□ No□

If yes, from whom, dates, reason(s) for therapy or treatment:

_____

_____

Have you ever been hospitalized for psychiatric reasons? Yes □No □

If yes, what hospital, date began/ended, precipitating event?

_____

_____

Family History of Mental Health Problems or Chemical Dependency:

_____

_____

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

□Depression □Bipolar Disorder □Schizophrenia disorders (i.e.psychosis, hallucinations) □Suicide	□ Physical / Sexual Abuse □ Substance Abuse (Alcohol/Drugs) □ Autism/Asperger's Syndrome Eating Disorder	□ Chronic Illness (please specify illness)_____ □ Accidental or Untimely Death □ ADHD or Learning Disorde Other

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:

Consent to Treatment

The undersigned client agrees to undertake mental health treatment with Kevin Richardson MSW, RSW. Treatment may be in the form of consultation, mental health treatment or psychotherapy. There are many different methods of treatment that I may use to address the problems that you wish to discuss with me. Participating in psychotherapy can result in various benefits to you, including: developing personal insight; reducing emotional distress; increasing your capacity for intimacy; and resolving other specific concerns. Psychotherapy can have risks as well. During the course of therapy you may experience uncomfortable feelings or you may experience unexpected consequences. Psychotherapy requires openness and your active involvement. You are encouraged to give me feedback and input about the course of your therapy as it proceeds. While success cannot be guaranteed, therapist and client join together in a good faith interest in meeting the goals of the client.

I HAVE READ THE ABOVE AND I AGREE TO THE TERMS AS OUTLINED.

_____

SIGNATURE OF CLIENT DATE RECEIVING TREATMENT

Payment Consent Form

1. The fee involved for clinical social work services is $100/hour. Fees are set on an hourly (50 minute) basis. Payment is expected at the time of your session, unless otherwise arranged.

2. You may obtain a printed receipt at the time of payment. A printed document can be mailed or emailed to you monthly or upon request, which will specify your session dates, fees for service, and payments received.

3. My services may be covered by third-party health insurance policies. You are still responsible for paying for your sessions at the treatment; however, we can assist you in faxing required documents to your insurer following each session to speed up the process of being reimbursed. Check with your insurance company to be sure you understand your coverage.

4. My services may be tax-deductible – please keep your receipts.

5. If you cancel an appointment within 24 hours, you will be charged half of the counseling session hourly rate, or $50. If you don't call or cancel online, and don't show for your appointment, you will be charged the full session rate of $100 ($200 for a double session or couples intake).

6. Telephone calls exceeding 10 minutes, other than the initial consultation, will be billed proportionately; as will professional telephone consultations (e.g. physicians, school personnel, lawyers) exceeding ten minutes. These services will be billed proportionately at the hourly rate and undertaken only with your explicit consent.

7. Written reports to other professionals or third-parties (e.g. insurance, government agencies) will be billed proportionately at the hourly rate and undertaken only with your explicit consent. Please understand that most insurance companies do not pay for such reports unless they request them.

I HAVE READ THE ABOVE AND I AGREE TO THE TERMS AS OUTLINED.

_____

SIGNATURE OF THE PERSON RESPONSIBLE FOR PAYMENT

DATE

Credit Card Payment Consent Form

Patient Name: _____
Print Last Name *First Name* *Middle Initial*

Name on Card (if different): _____

I authorize Kevin Richardson MSW, RSW, and Birch Wellness Center, to charge my credit or debit card for any late cancellations of appointments or no-shows on my behalf. If I cancel an appointment within 24 hours, I will be charged half of the counseling session hourly rate, or $50. If I don't call or cancel online, and don't show for my appointment, I will be charged the full session rate of $100 ($200 for a double session or couples intake). Kevin or his office manager will attempt to call you and make contact with you if you have no-showed, and then your card will be charged. I understand that setting counseling appointments and following through on them is my responsibility, and I will pay for them as part of that responsibility of being a counseling client. I understand the above statement and agree to have my credit or debit card charged for any late cancellations or no shows on my behalf.

Card holder Signature _____Date____ /_____ /____

I authorize Kevin Richardson, and Birch Wellness Center, to charge my credit/debit card for professional services as follows
Please Initial

____ This visit only, for the amount of $ _____

____ All visits in the next 12 months, beginning __/__ /__ , not to exceed $_____ total.

____ Recurring charges, date(s) of service___/__/__ to___/__/__, not to exceed $ _____,
Monthly_____, semimonthly_____, weekly_____, per visit_____.

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express

Credit Card Number _____ CVV Number _____
*A 3-digit number in reverse italicson the **back** of the credit card.*

Expiration Date_____ Postal Code _____Card holder Signature _____Date _____/_____ /_____
*Charges will appear on your credit card as **Birch Wellness Center** or **Kevin Richardson MSW, RSW**.*