Cognitive Advancements
A HEALTHY MIND IN A HEALTHY BODY

CLIENT INTAKE SHEET 2016

Client Name: _____
Last First Middle

D.O.B.: _____ **Sex:** ☐ **M** ☐ **F**
Year Month Day

Address: _____
Street Address

_____
City

_____
Postal Code

May we leave a detailed message?

Phone: _____ Residence — **Yes [ ]** **No [ ]**

_____ Work — **Yes [ ]** **No [ ]**

_____ Cell — **Yes [ ]** **No [ ]**

Email: _____

Emergency Contact Name_____**Emergency Contact Telephone Number**_____

EMPLOYER (company name):_____

Date of first Assessment: _____
(Day) (Month) (Year)

Please note: Cancellation of an appointment requires 24 hours notice. As of Jan 1, 2013 a $95 cash deposit or a Visa/MC/AMEX number will be kept on file and used if you fail to attend a scheduled appointment without 24 Hours notice.

_____ _____ _____ _____ **Exp Date:** _____

[ ] Visa, [ ] Master Card [ ] American Express [ ] Cash [ ] Cheque

($95 cash refunds will be returned on your last appointment, all other documents with your credit card information will be shredded)

By signing this form, you acknowledge and accept responsibility for payment of missed appointments.

_____
Signature of Client

_____
Signature of Parent or Legal Guardian

Date: _____

94 Charing Cross Street Brantford ON N3R 2H6 Phone 519-759-263 www.cogadvance.com cogadavance@rogers.com

INTAKE SHEET

Nature: What problem led you to seek help at this time?

_____
_____
_____

Apparent Cause of Crisis: What situations, events or stressors led to this problem?

_____
_____
_____

Symptoms:

_____
_____
_____
_____

History of Presenting Complaints:

_____
_____
_____

Have you had therapy before? If so what type of therapy & for what problems?

_____
_____
_____
_____

Did the client benefit from past therapy? Yes ☐ No ☐

Who do you see for your regular health care: (Doctor, Nurse, Healer, other) **[Circle]**

Employment history

Are You: Employed ☐ **Unemployed** ☐ **Self-employed** ☐
Name of the Company/employer you work for:_____
How long have you worked at this position:_____

Personal History: Are you

Marital Status: Married ☐ Divorced ☐ Single ☐ Common Law ☐
Separated ☐ Widowed ☐ Student ☐

Family History (children)

Dependants Name: _____ _____ _____
Dependants Age: _____ _____ _____
Dependants Sex ☐ **M** ☐ **F** ☐ **M** ☐ **F** ☐ **M** ☐ **F**

Do you have any siblings Yes_____ # _____No_____

Are you parents alive Yes____ No_____

Are you parents: Married ☐ Divorced ☐ Single ☐ Common Law ☐ Widowed ☐

Are there any mental health Issues in your family

Mom ☐ Grandmother ☐ Grandfather ☐ Sister ☐ Brother ☐
Dad ☐ Grandmother ☐ Grandfather ☐ Sister ☐ Brother ☐

What type of issues: - Depression, Anxiety, Personality disorders **[Circle issue]**

History of Mental Illness:_____

Mental history

Have you been treated for a Psychiatric Illness in the past year? ☐ Yes ☐No

If Yes, Diagnosis:

_____

_____

Was Medication prescribed? ☐ Yes ☐No If yes, list:_____

Current list of medications:

Name	Dose	Frequency	Time of last dose	Side Effects

Past adherence to prescribed treatment: ☐ Good ☐ Fair ☐ Poor

Do you take any of the following:
Vitamins:_____
Herbal Remedies: _____
Known allergies to medications: _____

If other treatment: What, Where, When?

_____

_____

HOW DID YOU HEAR ABOUT US?

News Paper □ Dr's Referral □ Friend □ Website □ E.A.P. □ Other □

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CONSENT FORM

This form will help you understand the counselling process and assist you in feeling more comfortable about counselling, its benefits, risks, and possible outcomes.

We will go through this form together. If there is anything you do not understand please let me know and I will try to help you better understand it.

About me: I am a therapist trained in CBT, Solution Focused Therapy, and Family Systems Therapy.

I work with various age groups and I am here when you need someone to talk to. I believe talking can help people sort out their feelings, and help them do things that are more positive. I know that each person is unique and special, and has something to offer. I want to help you discover your strengths and help you learn to build upon them. I am willing to help you to talk about whatever you feel will help you – even the tough stuff. My approach is to provide a safe and comfortable environment for us to know each other better so you gain trust and the courage to work on your issues. I know many support services we can access if additional help is required.

The time we spend together will provide you with an opportunity to work through challenging situations. I will keep everything you tell me in the utmost of confidence except:

- If you give me permission to tell your personal information to others, who may be able to help you (i.e.: teachers, parents, other professionals).
- If there is a risk of you harming yourself or someone else (I will seek appropriate assistance for you).
- If you tell me or I suspect someone is hurting your physically, sexually, or emotionally (I will contact the appropriate services and/or the police)
- If I am legally obligated to do so (Court ordered to testify)

What's not so great about counselling, the possibility of dealing with intense emotions like helplessness, insecurity, fear and anger. Also, other people may not support your efforts, nor is there a guarantee that counselling will successfully change the problem you are having.

94 Charing Cross Street Brantford ON N3R 2H8 Tel 519-759-2613 Fax 519- 304-4635

What's positive about counselling -- the possibility of feeling better about yourself and your life; learning how to solve your own problems; and, getting along better with other people. Counselling is voluntary. If you prefer to see another counsellor at any time, I will assist you with this.

I also want you to know that I keep written records of all of our sessions with a few details of what we talk about. These records are available for you to see upon written request. All records are kept for seven (7) years after which they are destroyed.

Other issues regarding consent that were discussed:_____
_____
_____
_____
_____
_____

I have read this form and I understand what it means. I agree to receive counselling from Dr. Michael Meade, HBSc, BEd, MEd, ND

Signature of the Client:_____Date: _____

Dr. Meade: _____ Date: _____