Breathing Room
Counselling Services

Confidential Intake Form

Client Information

Name:____
Address: ____
Phone: _____________________________Email: _________________________________

May I contact you by email? (Please Circle) Yes No

Is it okay to leave a message at the number provided? (Please Circle) Yes No

Date of birth: ____________________________Sex: _______________________________
Marital Status:____

Partners name (if applicable) ____

Children's Names	Date of Birth	Age
______________________________	__________	____
______________________________	__________	____
______________________________	__________	____
______________________________	__________	____
______________________________	__________	____

Person to contact in case of emergency: ______________________________________
Their relationship to you: ______________________ Phone #: ________________________

How did you hear about Breathing Room Counselling Services? ______________________

Please describe the issue(s) that you would like to work on in counselling.
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Please read the following and circle YES or NO

Have you previously been involved in counselling?	Yes	No
Are you currently taking any medication?	Yes	No
Do you drink alcohol, use prescription pain-killers, sleep aids or non-prescription drugs?	Yes	No

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Have you ever been hospitalized for mental health reasons?	Yes	No
Is there a history of mental health issues in your family?	Yes	No
Do you currently have thoughts of suicide?	Yes	No
Do you intend to carry them out?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever been physically or emotionally abused?	Yes	No
Have you ever been sexually abused or assaulted?	Yes	No
Has there been any violence in any of your relationships?	Yes	No

Please add any additional information which may be relevant:

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Fees and Payment Individual counselling fees: $__125.00________
Couples and family counselling fees: $___190.00_______

Payments are to be made by cash, email transfer or cheque.

NSF cheques will require a $25.00 service charge.

There will be a charge if an appointment is missed without a minimum of 24 hours notice.

Please consult with your human resources department or your insurance company to determine whether your employee extended benefit plan covers therapy provided by a Registered Therapeutic Counsellor.

Receipts are given that may be eligible to reduce your income taxes.

Authorization: I certify that I have read and understand the above information to the best of my knowledge.

I certify that I have accurately answered the above questions. I have read the above fee schedule and I accept full responsibility for payment of counselling fees.

Signature of Client (or parent of a minor) ________________________________
Date ________________________________