Client Information Form (This is a strictly confidential client record.)

Today's date: ____________________________

A. Identification

Your name: ______________________________Date of birth: _________________ Marital Status:_______

Home street address: ____

City: _____________________________Province: ______________Postal code: ____________________

EMAIL: ____

Home/evening phone: ______________________ CELL: ________________________________ Calls will be

discreet, but please indicate any restrictions:____

Who might I call on your behalf in case of an emergency (e.g. Medical emergency, high risk of suicide)?

Emergency contact: ____ Phone: _________________

B. Referral: Who gave you my name to call?

Name: ____ Phone: ______________________________

May I have your permission to thank this person for the referral? ___ Yes ___ No

How did this person explain how I might be of help to you?

____

C. Your medical care: Clinic/doctor's name: _________________________________ Phone: ___________

D. Employer: ____

Work phone: _________________________Calls will be discreet, but please indicate any restrictions:

____

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

____

____

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F. Treatment

1. Have you ever received psychological, psychiatric or counselling services before? ___No ___Yes

2. Have you ever taken medications for psychiatric or emotional problems? ___No ___Yes

G. Legal history: Are you currently involved in legal proceedings? ___No ___Yes

Consent to Treatment / Release of Information / Agreement to pay for professional services
(please excuse the formal language, it's a way to keep things clear)

Consent to Treatment

I acknowledge that I have received, have read and understand the "Information for Clients" brochure or website (www.arlenecassidy.net) about the therapy I am considering. I consent to take part in the therapy process with Arlene Cassidy, R.Psych. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that the Hakomi and Re-Creation of the Self methods may include techniques that involve touch. I also understand that I always have the right to refuse touch or any intervention suggested by this therapist. I understand that since the effectiveness of therapy depends on my participation as well as the therapist's that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time.

Signature: ____Date:__________________________

Release of Information

I, _______________________________________ understand that the information I give will be treated confidentially, to the limits of ethics and law. I give my consent to Arlene Cassidy, R.Psych. to request or share information regarding myself with other professionals, or professional organizations (eg. case consultations with other therapists/medical doctors), when it is considered necessary and beneficial to do so. Signature: ____ Date: ____________________

Additional information/requests re: confidentiality____

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Agreement to pay for professional services

I, _______________________________________, request that Arlene Cassidy, R.Psych. provide professional services to me and I agree to pay this therapist's fee of $180 per hour for these services. I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account. I agree to give 24 hours cancellation notice or pay a cancellation fee ($90.00, depending on circumstances).

Signature: ____ Date: _______________________

Additional information re: fee payment: ____

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