The Family Place

(*Fostering Wellness & Wholeness*)

Procedures and Policies

(ADULT INTAKE FORM)

CLIENT NAME_____ (printed name please)

PLEASE READ CAREFULLY

The Family Place is a mental and behavioural health centre committed to fostering wellness and wholeness in all individuals. We offer counselling and psychotherapy services for children, adolescents, adult individuals, couples and families.
The staff consists of psychologists and other qualified mental health professionals. We attempt to employ the most effective and efficient therapeutic approaches and techniques. Our approach to therapy emphasizes the importance of relationships, especially family relationships, in the process of change. Family members are encouraged to participate. On occasion, family members may experience some uneasiness or discomfort. Please understand that this may be necessary as part of making positive changes.

CONFIDENTIALITY: In general, the confidentiality of all communications between a client and a therapist is protected by law, and information cannot be released without your written permission. However, there are some exceptions:

- Under certain circumstances your file or therapist can be subpoenaed by attorneys or the courts.
- In accordance with ethical codes of mental health professionals, confidentiality does not include information about child abuse/neglect, sexual exploitation by other mental health professionals, elder abuse, or behaviour or threats to harm self or others.
- Any report of injury or suspected injury to a child must be reported to the proper authorities. Parents of minors will be informed of any life threatening activity.
- If communication with other persons requires a copy or copies of your records a fee may be assessed for this service.

Please discuss with your therapist any questions or concerns you may have regarding the limits to confidentiality.

APPOINTMENTS: Since we operate on an appointment basis, your appointment time and office space is reserved exclusively for you at the specified time. It is important that you notify the receptionist or your therapist 6-24 hours in advance if it is necessary to cancel or change your appointment. Failure to do so will result in the client forfeiting the fee for the session as if the appointment were kept.
Failure to do so a second time may result in a referral to another service. If you are more than 15 mins late, we will have no choice but to reschedule your appointment and the fee for the session will be forfeited. If there be a lack of correspondence

on your part for a period of at least one month, the therapy agreement will be terminated and any unused session fee will be forfeited.

Appointment reminders are sent to clients prior to each initial scheduled session. Please initial below beside the method by which you wish to receive the reminder. Please note that by initialing one of the methods below you are giving permission to be contacted via that method and waive all rights to confidentiality and privacy in regard to appointment scheduling. In addition, you understand that any charges for the service you choose is your responsibility.

_____ Text: Phone #: _____ Email: Address

_____

_____ Both (Text and Email) _____ No Reminder

SESSIONS: (Individual, Couples, or Family therapy): Individual sessions are 45 minutes long, while Family and Couple therapy sessions are 75 mins long. In most cases, you will have a regular time and day weekly when you see your therapist. If no therapy session occurs for a month or more, your case will be closed. We welcome and expect your active involvement in your therapy**.**

FEES: We are committed to providing quality services at a very affordable rate. We also believe in the importance of clients investing in therapy in order to gain the most from it. The fee for a session is N20, 000. Please discuss any fee questions, needs, or problems with your therapist.

BILLING & PAYMENTS: You will be expected to pay for each session upfront, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested or recommended.

REFERRAL: Often the person(s) who referred you would like to know that you came for counseling. This helps them to know if they have been helpful to you. May we inform them that you have come? Additional written permission will be requested from you BEFORE any information is given other than your attendance at this first appointment. NO __
YES__ Initial here _____
IF YES, please give their name: _____

Address: _____ City: _____ State: _____ Phone: _____

SERVICE EVALUATION: After therapy has ended would you be willing to assess our services through e-mail?
CONTACT VIA EMAIL: Y / N (please circle) EMAIL ADDRESS: _____

CONSENT FOR THERAPY: Please sign below, indicating that you have read and understand these procedures and policies, and that you agree to them and give your consent for therapy. If you have any questions please discuss them with your therapist BEFORE you sign. Thank you for your confidence in our services.

Client_____ DATE_____

CLIENT INFORMATION

Name: _____

Address: _____

_____

__ Male _____ Female Date of birth: _____ / _____ / _____ Age: _____ Phone: _____

Hobbies: _____

Goals: _____

RESPONSIBLE PARTY

(Please complete if someone other than you will be responsible for payment to TFP)

Organization: _____

Name: _____

Address: _____

_____

__ Male _____ Female Date of birth: _____ / _____ / _____ Age: _____ Phone: _____

Please answer the following questions so that your therapist will have some understanding of your situation. Only persons with access to your file will read this information, and it will remain strictly confidential along with any other personal information that you provide.

EMPLOYMENT

Occupation: _____ Place of Employment: _____

Work Phone: _____ How long have you been employed there? _____

EDUCATION

	Elementary	Secondary School	Tertiary
Circle the highest grade completed:	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6

Graduate Degree (specify) _____

Other Education or Training: _____

MARITAL INFORMATION

_____ Single _____ Married _____ Widowed _____ Divorced

Previously married: _____ Yes _____ No (if "yes" # of times _____)

Spouse Name: _____ Date of Birth: _____/_____/_____

Spouse's occupation: _____

Spouse's employer: _____

Please list all persons living in the home:

Name	Age	Sex	Relationship to you

List other children not living in your home:

Name	Age	Sex	Relationship to you

RELIGIOUS AFFILIATION _____

Reasons for Coming – Please check all that apply:

____Alcohol / Drug Use	____Fears	____Parents
____Ambition	____Finances	____Past Issues
____Anger	____Friends	____Relaxation
____Anxiety	____Health	____Religion
____Assertiveness	____Internet Use	____School
____Career Choices	____Insomnia	____Self-Concept/Esteem
____Children	____Legal Matters	____Self-Control
____Concentration	____Loneliness	____Separation
____Dating	____Marriage	____Sexual Issues
____Depression	____Nervousness	____Stress
____Divorce	____Nightmares	____Suicidal Thoughts
____Eating Problems	____Parenting	____Thoughts (mine)

Please describe any other areas/topics that you would like to discuss:

_____

_____

_____

_____

Have you sought professional help before? _____ If yes, when and where? _____

How were you referred to The Family Place? _____

_____

MEDICAL INFORMATION

CURRENT MEDICATIONS

LIST ANY CURRENT MEDICATIONS YOU ARE TAKING

Medication Prescribed	Physician	For Treatment Of:	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICATIONS

LIST MEDICATIONS TAKEN IN THE PAST

Medication Prescribed	Physician	For Treatment Of:	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Thank you. Please return these forms to the receptionist.