CHILD /ADOLESCENT INTAKE & THERAPEUTIC CONTRACT

Please complete on behalf of your child if she/he is under the age of 14. Ideally the document should be completed with your child's input.

Name of person completing this form: ____

Your relationship to the child: __________________________ Phone:

____

Email: ____

Name(s) of other parent(s)/legal guardian(s)/step parent(s):

____

____

Phone: __________________________ Email:_______________________________________

Child's name: ____Age: ________

Birthdate: ____________________

Child's Primary Address:____

Who does your child live with? *If applicable, please list all individuals who are currently living at the child's primary and secondary residence:_______________________________

____

____

Emergency contact's name and number:____

Referred by:____

ACADEMIC HISTORY

What school does your child attend?____________________________ Grade:__________

Do you have any concerns about your child's behaviour or academics at school? Y/ N (If yes, please describe)____

____

If applicable to presenting problem(s), school guidance counsellor's name and number:

____

Has your child experienced any of the following at school? Please circle where applicable.

Fighting Suspension Gang influences Drugs/alcohol Detention
Poor grades Behavioural problems Incomplete homework Lack of friends
Learning disabilities Poor attendance Peer pressure Anxiety Fear of failure

FAMILY HISTORY

Please describe your child's relationships with each of the following people, if applicable:

Biological mother: ____

Biological father: ____

Step-parents: ____

Legal guardians: ____

Siblings:____

Extended family:____

Friends:____

Have there been any deaths of or separations from parents, family members, nannies, babysitters or friends with whom your child was close or had frequent contact?

____

MEDICAL HISTORY

Please list any significant medical problems that your child has ever had:______________

____

Please list any medications your child currently takes, and what they are taken for:______

____

REASON FOR REFERRAL

Please circle the issues or symptoms you are currently concerned about with respect to your child:

Sad/depressed mood   Sleep disturbances   Hearing voices   Trauma

Suicidal thoughts   Worries/anxiety   Nightmares   Seeing things others don't see

Perfectionism   Lack of interest in activities   Often fatigued   Anxiety attacks

Withdrawn   Poor attention/concentration   Irritable   Hyperactivity

Romantic problems   Running Away   Trouble with the law   Sexual identity

Academic performance   School attendance   Victim of bullying   Internet addiction

Inappropriate sexual behavior   Repetitive behaviours   Shyness   Social skills

Aggressive behaviour   Appetite Changes   Restrictive eating /binging/purging

Defiant towards adults   Conflict at home   Bereavement   Stealing/lying

Alcohol/drug use   Self-injurious behaviour   Parental divorce/separation

When did these problems start? What was going on in your child's life at that time?

____

____

____

Does your child agree with your understanding of the presenting issue(s)? Y/N

If no, please describe how your child views your current concerns:____________________

____

____

What are your child's positive qualities and skills? What do you like about your child?

____

____

____

What would you like them to achieve by attending family therapy?

____

____

____

Is there anything else that you would like to mention?______________________________

____

____

____

Thank you for taking the time to complete this extensive questionnaire. It helps me to help you!

Client's Signature:____________________________________

Mothers' Signature:__________________________________

Father's Signature:___________________________________

Date:_________________

THERAPEUTIC CONTRACT

I consent to treatment with Adrienne Durst. I understand that I can terminate therapy at any time. Confidentiality is a fundamental principle of therapy. I understand that no information shared or disclosed between myself and Adrienne will be disclosed to any third party without my written permission, except for the following circumstances:

1. DUTY TO WARN & PROTECT: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify the family of the client and/or required authorities.

2. ABUSE OF CHILDREN & VULNERABLE ADULTS

If a client states or suggest that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult) or that a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social services and/or legal authorities.

3. PRENATAL EXPOSURE

Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

4. INSURANCE PROVIDERS

Insurance companies and other third-party payers are given information that they request regarding services to clients.

5. SUPERVISION/CONSULTATION

The therapist may discuss treatment for the purpose of supervision and consultation when needed, with the understanding that any identifying characteristics remain confidential. If you ever want me to share information with someone else (such as your doctor), you need to sign a written authorization form giving me consent to do so.

SESSIONS

Sessions are 50 minutes in length and take place weekly. If you appear late for a session that time will be lost at your expense. Couple and family therapy sessions begin only

when everyone is present. Longer and more frequent sessions may be arranged by mutual agreement. If several members of your family attend sessions with me, or when working with partners in couples therapy, information shared with me by one family member is not necessarily confidential from others in treatment.

FEES

The rate per session is 170 dollars for individuals and 190 dollars for couples and family therapy. Fees are payable at the beginning of each session and can be made either by cash, check or etransfer. I am only available to discuss scheduling arrangements by phone. It is recommended that if there is information that you want to discuss that an additional session is booked, as phone conversations over 15 minutes will be billed for one therapeutic hour. There will be a fee for any requested documents. Fees are re-evaluated and subject to change on a yearly basis. Fees for couple or family therapy remain the same even if you are seen during an individual session without your partner, spouse, parent or other family member.

INSURANCE

I am a member of the Order of Social Workers of Quebec as a Marital and Family Therapist, my permit number is # DURA05-02-180. I also hold a Psychotherapist permit through the Ordre des Psychologues du Quebec and my permit number is #60581-13. Additionally, I can issue receipts under the Academy of Naturopaths and Naturotherapist of Canada and my permit number is #12-5715. Since insurance policies may vary, it is important to read your policy carefully and understand the extent of your coverage. If receipts are needed for insurance please advise me.

CANCELLATION POLICY

You are required to give 48 hours if you are unable to attend the session. Cancellations received less then two business days in advance and missed appointments will be charged at the full fee, except in instances of illness or emergency.

TERMS & AGREEMENTS

You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements. I will not testify or otherwise get involved with lawyers during civil litigation or other legal proceedings. In the unusual circumstances that you are involved in a legal proceeding that requires my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the complexity and difficulty of legal involvement I charge a separate fee.

I offer in person therapy and teletherapy. Recording any therapeutic session whether it be in face to face therapy, audio or videoconferencing is prohibited by any party including the therapist or client without the other party's written permission. Violation of this policy by covert recording will lead to termination of therapy.

Please note that during the summer months I will only be offering teletherapy sessions but will resume in-person therapy from September to June. Lastly, I may bring my dog named Clara, who is a Golden Retriever, to my office. She's lovely.

I have read and understand Adrienne Durst's therapeutic contract and agree to abide by its terms.

Mother's Signature:____

Father's Signature:____

Signature of Therapist:____

Date:________________________