

## INDIVIDUAL INTAKE & THERAPEUTIC CONTRACT

\*To be completed by individuals ages 14+

Name: \_\_\_\_\_

Name of parent(s) /guardian(s) if you are under the age of 18:

\_\_\_\_\_

Address: \_\_\_\_\_

RES #: \_\_\_\_\_ ( May I leave a message Y/N )

Work #: \_\_\_\_\_ ( May I leave a message Y/N )

Mobile #: \_\_\_\_\_ ( May I leave a message Y/N )

Email address (Email correspondence is not considered a confidential method of communication): \_\_\_\_\_

May I email you? Y/N

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Who referred you to me? \_\_\_\_\_

Are you currently employed? ( Y/N)

Occupation: \_\_\_\_\_

Marital Status (please circle one)

Never Married   Cohabiting   Married   Separated   Divorced   Widowed

List the name(s) of your children with their age and gender: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who do you live with? \_\_\_\_\_

Emergency contact's name and number: \_\_\_\_\_

\_\_\_\_\_

### MEDICAL HISTORY

How would you rate your current physical health? ( please circle one )

Poor   Unsatisfactory   Satisfactory   Good   Very Good

Name of your physician and phone number: \_\_\_\_\_

When was your last check up? \_\_\_\_\_

Please list any specific health problems you are currently experiencing and any medications you currently take: \_\_\_\_\_  
\_\_\_\_\_

Did you experience any significant illnesses during childhood or adolescence?  
\_\_\_\_\_  
\_\_\_\_\_

How would you rate your current sleeping habits? (Please circle one)

Poor      Unsatisfactory      Satisfactory      Good      Very Good

How many times per week do you exercise? \_\_\_\_\_

What types of exercise do you participate in? \_\_\_\_\_  
\_\_\_\_\_

Please list any difficulties you have with your appetite or eating habits:  
\_\_\_\_\_  
\_\_\_\_\_

Do you drink alcohol? If yes, how much?  
\_\_\_\_\_

Do you use recreational drugs? If so, what kind and how often? \_\_\_\_\_  
\_\_\_\_\_

Are you currently experiencing overwhelming sadness, grief or depression? Y/N  
If yes, for approximately for how long? \_\_\_\_\_

Are you currently experiencing anxiety? Y/N  
If yes, for approximately for how long? \_\_\_\_\_

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Y/N  
If yes, when and for how long? Name(s) of previous therapist(s):  
\_\_\_\_\_  
\_\_\_\_\_

**CIRCLE ANY OF THE FOLLOWING THAT MAY APPLY TO YOU:**

- Headaches    Inferiority feelings    Shy with people    Dizziness    Feel tense
- Can't make friends    Fainting spells    Feeling panicky    Afraid of people
- No appetite    Binge eating    Fears and phobias    Poor home conditions
- Obsessions    Unable to enjoy yourself    Stomach trouble    Depressed/Sad
- Always worried    Suicidal feelings    Often fatigued    Hallucinations
- Need for tranquilizers    Alcoholism    Overambitious    Financial problems
- Infidelity    Job problems    Nightmares    Unable to relax    Insomnia    Gambling
- Recurrent dreams    Sexual problems    Alcohol/Drug Use    Sexual Identity
- Perfectionism    Bereavement    Self-injurious behaviour    Divorce/separation
- Trauma    Trouble with the law    Legal matters    Aggressive behaviour
- Restrictive eating    Anxiety    Internet/gaming addiction    Discrimination

**FAMILY OF ORIGIN**

Indicate if there is a family history of any of the following. If yes, please indicate the family member's relationship to you:

Alcohol/Substance Abuse: Y/N \_\_\_\_\_

Anxiety: Y/N \_\_\_\_\_

Depression: Y/N \_\_\_\_\_

Eating Disorders: Y/N \_\_\_\_\_

Schizophrenia: Y/N \_\_\_\_\_

Suicide Attempts: Y/N \_\_\_\_\_

Obsessive Compulsive Behaviour: Y/N \_\_\_\_\_

Domestic Violence: Y/N \_\_\_\_\_

Father's name and age: \_\_\_\_\_

His occupation: \_\_\_\_\_

Health (If deceased: circumstance and how loss affected you): \_\_\_\_\_

---

---

Describe your father's personality and the nature of your relationship with him past and present: \_\_\_\_\_

---

---

Mother's name and age: \_\_\_\_\_

Her occupation: \_\_\_\_\_

Health (If deceased: circumstance and how the loss affected you): \_\_\_\_\_

---

---

Describe your mother's personality and the nature of your relationship with her past and present: \_\_\_\_\_

---

---

### **SIBLINGS**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Age : \_\_\_\_\_

Occupation: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Occupation: \_\_\_\_\_

Describe your relationship with your siblings (past and present): \_\_\_\_\_

---

---

---

---

Were there other adults involved in your upbringing? Y/N

If yes, whom? \_\_\_\_\_

Describe the atmosphere in your childhood home:

---

---

---

### **ROMANTIC RELATIONSHIPS**

Are you currently in a relationship? Y/N

If yes, for how long? \_\_\_\_\_

Do you live with your partner? Y/N

Describe your partner's personality: \_\_\_\_\_

---

---

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

Give details on any previous marriages or long-term relationships? \_\_\_\_\_

---

---

### **SELF DESCRIPTION**

What significant life changes or stressful events have you experienced recently?

---

---

---

Do you enjoy your work? Is there anything stressful about your current work?

---

---

---

Do you have any spiritual or cultural affiliations? Y/N If yes, please describe: \_\_\_\_\_

---

---

What do you consider to be some of your positive qualities and skills? What do you like about yourself? \_\_\_\_\_

---

---

What do you dislike about yourself and would like to change? \_\_\_\_\_

---

What do you do for pleasure or as a way to unwind? \_\_\_\_\_

---

What brings you to therapy and what would you like to accomplish? \_\_\_\_\_

---

---

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

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 e-transfer. 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 than 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.

Client's signature: \_\_\_\_\_

Signature of therapist: \_\_\_\_\_

Date: \_\_\_\_\_

