Consent for the collection of personal information

I understand that to provide me with psychological services my psychologist will collect some personal information about me (e.g. home telephone number, address, personal concerns).

I have reviewed Dr. Alia W. Offman's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy and they have been answered to my satisfaction.

I understand there are some rare exceptions to these commitments.

I agree to Dr. Alia W. Offman C.Psych coll1ecting, using and disclosing personal information about me as set out above and in Privacy Policy.

_____ _____

Client's Signature Date

_____

Printed Name

Dr. Alia W. Offman, C.Psych

613.264.1985 • www.self-balance.ca • 1211 Drummond School Rd, Perth, ON K7H 3C8 • alia.offman@self-balance.ca

Our Agreement

I, _____, the client, understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the therapist, before I start (or the client starts) formal therapy. I also understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this brochure, I can talk with you about them, and you will do your best to answer them.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the issues and points in this form. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this form. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

Dr. Alia W. Offman, C.Psych

613.264.1985 • www.self-balance.ca • 1211 Drummond School Rd, Perth, ON K7H 3C8 • alia.offman@self-balance.ca

Intake Assessment Form

Please provide the following information and answer the questions below. Please note; **Information you provide here is protected as confidential information.** Please Fill out this form and bring it to your first session.

Today's Date: _____

GENERAL INFORMATION

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age: _____ Gender [ ] Male [ ] Female

Address: _____

(Street and Number)

_____

(City)

Home Phone: ( ) May we leave a message Yes ☐ No ☐

Cell/Other Phone: ( ) May we leave a message Yes ☐ No ☐

E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Cultural Considerations: _____

Religion: _____

Education

High School: _____

(Where) (Last grade completed) (Graduated? Y or N)

Post High School Education:
Explain:

_____

_____

Is or was school performance a concern for you?
If yes, explain:

_____

_____

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Never

Years Married: _____ Years Divorced: _____

Are you currently in a romantic relationship? _____

If yes, for how long? _____

On a scale of 1-10 how would you rate your relationship? _____

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

_____

_____

Children:

Name	Age	Sex	Occupation or Grade	Living with Client	Biological, Adopted, or Step

Your Brothers and Sisters:

Name	Age	Biological, Adopted, Or Step

Other Household Members

Name	Age	Relationship to Client

Who currently lives in your household?

Describe your relationship with:

Parents: _____

Siblings: _____

Extended Family Members: _____

Husband/Wife/Significant Other:

_____

Your Children: _____

Health History

Primary Physician: _____

Primary Physicians Address: _____

Primary Physicians Phone: _____Date of Last Exam_____

Please List Allergies if Any_____

Have you previously received any type of mental health services (Psychotherapy, Psychiatric services, ECT.)?
Yes_____
No_____
If yes, when and where?

_____

_____

List any support groups you have attended in the past or presently:

_____

_____

Was support group attendance helpful?

_____

_____

Are you currently taking any prescription medications?
Yes_____
No_____
Please list:

_____

_____

Have you ever been prescribed psychiatric medication?
Yes_____
No_____
Please list:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMAITON

*How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:_____

_____

*How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

Yes_____ No_____

If yes, approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin to experience this?

_____

Are you currently experiencing any chronic pain?

If yes, please describe:

_____

_____

Are any physical characteristics or body image a concern? Explain:

_____

_____

Is sexual functioning an area of concern for you? Explain:

_____

_____

Substance Use

Do you drink alcohol more than once a week? Yes_____ No_____

If yes, how often? _____

Is alcohol an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

How often do you engage in recreational drug use?

Daily____ Weekly____ Monthly _____ Never____

Is recreational drug use an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle ECT.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Abuse History

Have you experienced physical, sexual or emotional abuse? Yes___ No___

If yes, explain_____

Legal History

Do you have a history of any legal charges? Yes_____ No_____

If yes,
explain_____

_____

Are you currently on probation or parole? Yes_____ No_____

If yes,
explain_____

_____

Is treatment court ordered? Yes_____ No_____

Employment

Are you currently employed? Yes____ No_____

If yes, what is your current employment situation?

_____

_____

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

_____

_____

Additional Information

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Is there anything else you feel we should know, or that you are concerned about?

X

Signature of Person Completing Form

self balance

PSYCHOLOGICAL SERVICES

Email use agreement

Name:

Email address

By signing below, I agree that Dr. Alia W. Offman may use my email address for the following purposes:

□ Appointment reminders and bookings

□ Cancelling and rescheduling appointments

□ Information related to billing and payment

By signing below,

1. I agree to the use of my email address for the purposes checked above.
2. I acknowledge that email is neither secure nor confidential, therefore I will not use it to communicate for other than administrative purposes.

I am aware that I can revoke permission to communicate with me by email purposes listed above at any time. Dr. Alia Offman will not share my information with anyone.

Signature:

_____

Date:

_____

Dr. Alia W. Offman, C.Psych

613.264.1985 • www.self-balance.ca • 1211 Drummond School Rd, Perth, ON K7H 3C8 • alia.offman@self-balance.ca