Renewed Pathways

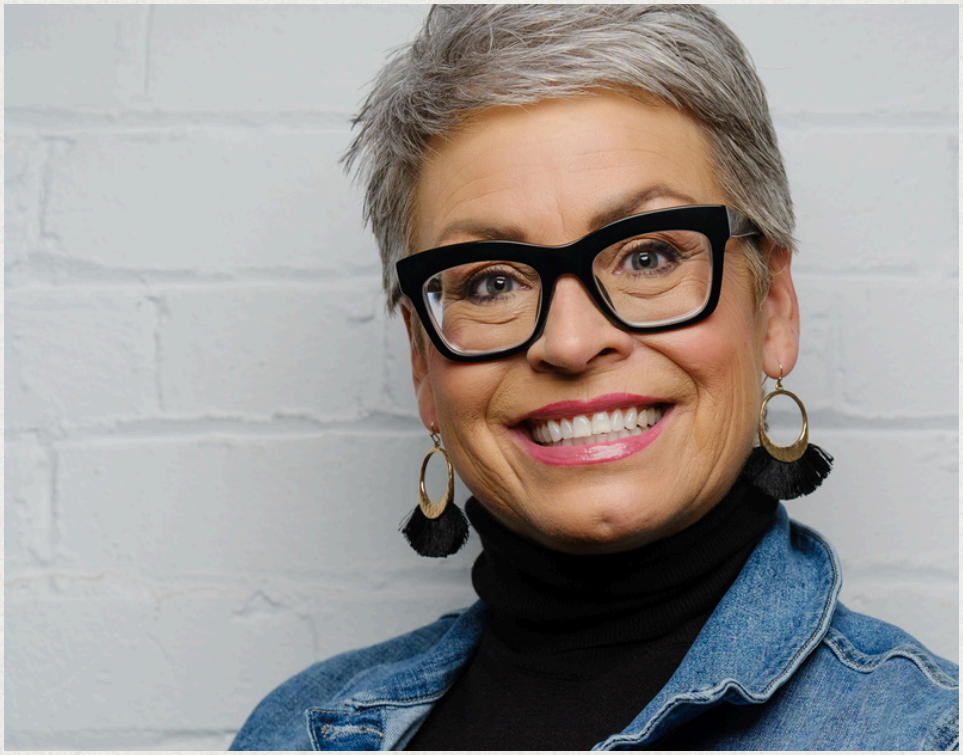
Counselling and Consulting

CLIENT WELCOME PACKET

Welcome Friend

Hello, I am so glad you found me! Unfortunately, it is probably because you are struggling. I know from personal experience how scary it can be to even think about sharing the most private parts of your trauma. I want you to know that I am passionate about helping those who have experienced trauma. Having gone through early childhood trauma myself, my desire to heal and support others began at a young age. I have 22 years of experience working with children, individuals and families affected by trauma of all sorts in an emergency room and intensive care setting.

-Sandy



Welcome, and thank you for taking this step toward caring for yourself. I'm glad you're here.

Beginning counselling can bring up a mix of feelings—hope, uncertainty, relief, or even a bit of nervousness. All of that is completely normal. My goal is to offer you a space that feels safe, respectful, and supportive, where you can speak openly and be met with understanding and care.

Counselling is a collaborative process. We will move at a pace that feels right for you, focusing on what matters most in your life and what you hope to gain from our work together. There is no pressure to have everything figured out or to know exactly what to say—showing up as you are is enough.

Your privacy and confidentiality are very important, and we will review this together so you feel informed and comfortable. If you ever have questions, concerns, or need clarification at any point, I encourage you to bring them forward.

I appreciate the trust it takes to begin counselling and I look forward to supporting you on your journey.

CONTACT INFORMATION SHEET

CONTACT INFORMATION

Name: _____
Birth Date: *(MM/DD/YYYY)*
_____/_____/_____
Age: _____
Gender: _____
Pronouns: _____
Email: _____
May We Send You An Email?
Yes: _____ **No:** _____

Primary Phone: (_____) _____
Secondary Phone: (_____) _____
May We Leave A Voicemail?
Yes: _____ **No:** _____
Address: _____
City: _____
Province: _____ **Postal Code:** _____

OCCUPATION INFORMATION

Employer:_____
Work Phone: (_____) _____
May We Call this Number?
Yes: _____ **No:** _____

Job Title:_____
Address:_____
City: _____
Province: _____ **Postal Code:** _____

EMERGENCY CONTACT INFORMATION

Name:_____
Relationship:_____
Email:_____

Phone: (_____) _____ - _____
May We Call this Number?
Yes: _____ **No:** _____

PLEASE NOTE:
EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNICATION
UNLESS SENT USING AN ENCRYPTED SERVER.

CLIENT INTAKE FORM

Date of first appointment: _____

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- ☐ Medical Provider:
- ☐ Insurance Provider:
- ☐ My Website:
- ☐ PsychologyToday
- ☐ Friend/Family:
- ☐ Other:

Have you previously received any type of mental health services?

- ☐ Yes
- ☐ No

If yes, which of the following:

- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalizations
- ☐ Inpatient Hospitalization

If yes, please provide:

Name of provider or facility: _____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Briefly, what brings you in today:_____

When did your problems first start? Within the last:

- ☐ 30 days
- ☐ 6-12 months
- ☐ 2 years
- ☐ During adolescence
- ☐ During childhood

What areas of your life have been affected because of this problem? _____

_____

_____

Are you currently experiencing overwhelming sadness, grief or depression?

- ☐Yes
- ☐No

If yes, for approximately how long? _____

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

- ☐ Yes
- ☐ No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced: _____

_____

_____

_____

_____

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

_____

_____

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

_____

_____

Family History

Where were you born? _____

Where did you grow up? _____

- ☐ City
- ☐ Suburbs
- ☐ Country

Please list your parents and siblings.

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation? _____

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, etc.).

Condition	Please select	List Family Member
Alcohol/Substance Abuse	No	
Anxiety	No	
Depression	No	
Domestic Violence	No	
Sexual Abuse	No	
Eating Disorders	No	
Obesity	No	
Obsessive Compulsive Disorder	No	
Schizophrenia	No	
Suicide Attempts	No	
Other diagnosed mental health condition?	No	

If yes, please list: _____

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced - For how long?
- ☐ Widowed: Please provide your partners name and year deceased: _____

If married, how long have you been married for and what is your partners name:

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship?

- ☐ Yes -- How long? ____
- ☐ No

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax: _____

How would you rate your current physical health?

- ☐Poor
- ☐Unsatisfactory
- ☐Satisfactory
- ☐Good
- ☐Very Good

Please list any specific health problems you are currently experiencing: _____
_____
_____

How would you rate your current sleeping habits?

- ☐Poor
- ☐Unsatisfactory
- ☐Satisfactory
- ☐Good
- ☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- ☐Falling asleep
- ☐Staying asleep
- ☐Awakening early
- ☐Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____
What types of exercise do you participate in:_____
_____
_____

Are you currently experiencing any chronic pain?

- ☐ No
- ☐ Yes

If yes, please describe:_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:_____

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work? _____
_____

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

Full Name:_____ Full Name of Guardian (if under 18):_____

Signature:_____ Signature of Guardian:_____

Date:_____ Date:_____

Credit Card Information

(Please note: Credit card information is stored securely and is not kept in plain text.)

- Name on Card: _____
- Card Type: ☐ Visa ☐ MasterCard ☐ American Express
- Card Number: _____
- Expiration Date (MM/YY): _____
- Security Code (CVV): _____
- Billing Postal Code: _____

Authorization

Please initial each statement to indicate your understanding and agreement:

____ Authorization to Charge

I authorize _____ (practice/therapist name) to charge my credit card for counselling services provided to me.

____ Missed or Late-Cancelled Appointments

I understand that my credit card may be charged for missed appointments or late cancellations in accordance with the cancellation policy.

____ Outstanding Balances

I authorize charges for any outstanding balances not paid at the time of service.

____ Declined Payments

I understand that if my card is declined, I am responsible for providing an alternative form of payment promptly.

Cancellation and Fees

I acknowledge that I have received and reviewed the practice's cancellation and fee policies, including notice requirements for cancelling or rescheduling appointments.

Confidentiality and Security

I understand that my credit card information will be stored and processed securely and used only for authorized purposes.

Client Acknowledgement and Consent

I certify that I am the authorized cardholder or have permission from the cardholder to use this card. I understand that this authorization will remain in effect unless I provide written notice to revoke it.

Cardholder Signature: _____

Date: _____

Printed Name: _____

Informed Consent Agreement for Therapy with Related Clients

This form outlines the potential risks, limitations, and boundaries involved when two or more related individuals (e.g., partners, family members) choose to receive therapy from the same therapist. Please review each section carefully before signing.

Nature of the Therapeutic Relationship

☐ I understand that receiving therapy from the same therapist as a related individual may create dual relationships and potential conflicts of interest.

☐ I understand that the therapist will make reasonable efforts to remain neutral and provide equitable support to all parties involved.

Confidentiality

☐ I understand that my privacy will be respected; however, absolute confidentiality cannot be guaranteed when related individuals work with the same therapist.

☐ I understand that information shared in individual sessions will not be disclosed to others without my explicit consent, except where disclosure is legally required (e.g., risk of harm to self or others, abuse, or court order).

Potential Risks

☐ I understand that there is a possibility of perceived or actual bias or favoritism.

☐ I understand that managing boundaries may be more complex in this type of therapeutic arrangement.

☐ I understand that conflicts between related individuals may impact the therapeutic process or outcomes.

Alternatives

☐ I understand that I have the option to seek therapy from a different provider and that doing so is often recommended to avoid ethical or boundary-related concerns.

Client 1 Name: _____
Client 1 Signature: _____
Date: _____

Client 2 Name: _____
Client 2 Signature: _____
Date: _____

Therapist Signature: _____
Date: _____

Limits of Confidentiality

Client Information

- ***Client Name:*** _____
- ***Date of Birth:*** _____
- ***Therapist Name:*** _____
- ***Date:*** _____

Purpose of Confidentiality

Confidentiality is a fundamental part of the counselling relationship. Information shared during counselling sessions is kept private and protected in accordance with professional, ethical, and legal standards.

However, there are specific ***legal and ethical limits to confidentiality****, which are outlined below.*

Please read each section carefully and initial to indicate your understanding.

Limits of Confidentiality

I understand that my therapist ***may be required to disclose information without my consent*** *in the following circumstances:*

____ Risk of Harm to Self or Others

If there is reasonable concern that I may pose a serious risk of harm to myself or to another person, information may be disclosed to appropriate individuals or authorities to ensure safety.

____ Abuse or Neglect of a Child or Vulnerable Person

If there is suspected or disclosed abuse or neglect of a child, elder, or other vulnerable person, the therapist is legally required to report this to the appropriate authorities.

____ Court Orders or Legal Requirements

If records or testimony are subpoenaed or otherwise legally required by a court of law, the therapist may be required to disclose relevant information.

____ Professional Consultation

The therapist may consult with supervisors or professional colleagues for the purpose of ensuring quality care. Identifying information will be minimized whenever possible.

____ Billing and Administrative Purposes

Limited information may be shared with insurance providers or third-party billing services when applicable.

Confidentiality of Records

- *Counselling records are stored securely and accessed only as permitted by law.*
- *I understand that I may request access to my records, subject to legal and ethical guidelines.*

Client Acknowledgement and Consent

I acknowledge that:

- *I have read and understand the limits of confidentiality described above.*
- *I have had the opportunity to ask questions about confidentiality.*
- *I understand that confidentiality cannot be guaranteed in all situations.*

By signing below, I indicate my informed consent.

Client Signature: _____

Date: _____

Therapist Signature: _____

Date: _____