Le Psych Loft
T: 514-600-5036
E: lsampasivam@lepsychloft.com
W: www.lepsychloft.com

Date: ___________________

INTAKE FORM AND CONSENT

PERSONAL INFORMATION

First Name: _________________________ Last Name: _________________________
Age: ______ Birthday: ___________________________
Ethnicity: __________________________ Gender: ______

Home Address: ____
Marital Status: ___________________________
Number and age of children: ____
Who lives in the home? ____
Cell #: _____________________________ Home #: ___________________________
Work #: ___________________________ Email: _____________________________

Name of emergency contact: ___________________________
Phone #: ___________________________

EMPLOYMENT INFORMATION

☐ Working (full-time or part-time)
☐ Not working
☐ On sick leave

ACADEMIC INFORMATION

☐ Attending school (full-time or part-time)
School: ___________________________
Program: ___________________________
Year: ___________________________
Typical Grades: ___________________________

☐ Not attending school
Highest level of education completed: ___________________________

How did you find out about the clinic?

☐ Psychology Today
☐ Google
☐ EAP Program
☐ Word of mouth
☐ Doctor
☐ OPQ

Other: _________________________

Le Psych Loft
T: 514-600-5036
E:lsampasivam@lepsychloft.com
W: www.lepsychloft.com

REASON FOR VISIT:

____
____
____
____
____

When did these problems start? What was going on in your life around that time?

____
____
____
____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any **psychiatric conditions** you have been diagnosed with:

____
____
____

Please list any **medical conditions** you have been diagnosed with:

____
____
____

Please list any **medications** you take and what you take them for:

____
____
____

Name of family doctor: ________________________ Phone #: _______________________
Last visit date: ________________________________
Results: _____________________________________

Name of psychiatrist: _________________________ Phone #: _______________________
Last visit date: ________________________________
Results: _____________________________________

LE P·S·Y·C·H LOFT

Le Psych Loft
T: 514-600-5036
E:lsampasivam@lepsychloft.com
W: www.lepsychloft.com

MENTAL HEALTH TREATMENT HISTORY

Have you been hospitalized for any mental health problem?
If yes, please describe when, where, and how you were hospitalized.

____
____
____

Have you consulted any **mental health professionals** in the past?
If yes, please describe the nature of the treatment (i.e., when, type of professional, reason, nature and outcome of treatment).

____
____
____

CURRENT HABITS

Please describe your current habits in the following areas:
Smoking: ____
Drinking: ____
Drug Use: ____
Gambling: ____
Exercise: ____
Eating: ____
Sleeping: ____
Fun/Relaxation: ____

RELATIONSHIPS

Please describe your relationship with each of the following people (if applicable):
Mother: ____
Father: ____
Step-parents: ____
Guardian: ____
Siblings: ____
Romantic Partner: ____
Children: ____
Friends: ____
Colleagues/Classmates: ____
Number of close, supportive relationships: ____________________________________

Le Psych Loft
T: 514-600-5036
E:lsampasivam@lepsychloft.com
W: www.lepsychloft.com

OTHER

What are your positive qualities/traits?

____
____
____

What are your future plans (e.g., career, personal life)?

____
____
____

What are your goals for therapy?

____
____
____

What are you expectations for therapy (e.g., what type of therapist are you looking for, what are your expectations regarding the sessions)?

____
____
____

How motivated do you feel to work on your goals? Any concerns?

____
____
____

Anything else you would like to mention?

____
____
____

LE P·S·Y·C·H LOFT

Le Psych Loft
T: 514-600-5036
E:lsampasivam@lepsychloft.com
W: www.lepsychloft.com

CONSENT FORM TO RECEIVE PSYCHOLOGICAL SERVICES

This form explains the nature of the services that will be provided. As consent is an ongoing process, any changes that may influence your consent will be discussed with you.

Approach: The therapeutic process typically consists of an (1) assessment phase where the therapist tries to better understand your areas of concern, (2) treatment phase, and a (3) termination phase to prepare for the end of treatment Throughout therapy you are invited to share any questions or concerns you have so that the therapist is aware and able to personalize treatment strategies that better match your needs. Services are by appointment only; in an emergency please call 911 or go to the emergency.

Fees and payment: Sessions are approximately 45-50 minutes in length. Every attempt is made to see clients on time and therefore payment is due at the start of each session. **TWENTY-FOUR (24) hours' notice is required to CANCEL or RESCHEDULE appointments to avoid being billed for the full fee of the missed session. THE ONLY EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES.**

Confidentiality: Psychological records may include items such as personal information, session notes, and evaluations. They will be shredded 7 years after your file has been closed, as per the requirements of the Ordre des Psychologues de Quebec (OPQ). No information about you can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. **Exceptions include:** (1) when children are under 14 years of age, and their parents/legal guardians want access to their file, (2) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group, (3) suspected or known abuse or neglect of a child or an older adult, (4) unsafe operation of a motor vehicle (5) requests ordered by a court of law or the OPQ, or (6) access is required by other personnel (e.g., administrative staff) to carry out their professional duties. Therapists must, as soon as the interest of their client so requires, receive supervision, consult another therapist, a member of another professional order, or another competent person. Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You may refuse any therapeutic suggestions offered to you, or to suspend or cease treatment at any time without penalty. If you decide to stop treatment for any reason, please notify your therapist so that your file can be closed and/or you can be referred to another resource. If you stop treatment without an explanation, your file will automatically be closed after 30 days.

Consent to treatment: I have read and understood the above information. I agree with the above consent form and freely consent to receive psychological services.

Name: ____ Signature: ___________________________
Date: ____

*For clients ages 13 and younger:
Name of parent/guardian: _________________________ Signature: ___________________________
Date: ____

Name of parent/guardian: _________________________ Signature: ___________________________
Date: ____