new perspectives counselling ltd.
caroline krupica & associates

CLIENT INTAKE FORM

Today's Date:	Therapist:
Session Type: ❑IN ❑CP ❑CI ❑FN ❑VS ❑ComP ❑ASSMT ❑ANG ❑EAP ❑FC ❑____	❑ Limits of Confidentiality Reviewed

PERSONAL INFORMATION

Client's Last Name: First: Middle:	❑Mr. ❑Mrs	❑Miss. ❑Ms.	Martial Status ❑Sin ❑Mar ❑Div ❑Sep ❑Wid	
Street Address:	Birth Date:	Age:	Sex: ❑ M ❑ F	
City:	Prov:	Postal Code:		
Home Phone: Msg ok? ❑Y or ❑N	Cell Phone: Msg ok? ❑ Y or ❑ N	Email Address: I provide permission to New Perspectives to communicate with me via email to receive updates, etc: Yes No ☐ ☐		
Occupation:	Employer:	Work Phone:	Msg ok? ❑ Y or ❑ N	
Emergency Contact Person:	Relationship to Client:	Home/Cell Phone:	Work Phone:	
Family Physician:	Address:	Phone:	Fax:	

Are you taking Medication? ❑ Y or ❑ N
If yes, please list: _____ Reason: _____ How Long: _____
_____ Reason: _____ How Long: _____
_____ Reason: _____ How Long: _____

REFERRAL INFORMATION

Please inform us about the services you are interested in receiving:
❑ Individual ❑ Couple ❑ Family ❑ Child/Adolescent ❑ Victim Services ❑ WSIB ❑ Criminal Injuries ❑ EAP ❑ Anger Management ❑ Career Counselling/Assessment ❑ Psychological Assessment ❑ Diagnostic Assessment ❑ MVA Assessment ❑ Other _____

Have you attended counselling previously? ❑ Y or ❑ N
If yes, when? _____ Reasons? _____

Was counseling helpful? _____

Explain _____

Based on your perception, briefly describe the difficulties you are experiencing.

Please List three goal you would like to achieve during the couselling process
1)

2)

3)

How did you hear about the services at New Perspectives?
❑ Website/Internet ❑ Previous Client ❑ Family/Friend ❑ Print Media ❑ Lawyer/Probation Officer ❑ Other _____

❑ Medical Doctor, Doctor's Name _____ Phone _____

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FOR ANGER MANAGEMENT OR LEGAL INVOLVEMENT CASES ONLY *(REQUIRED)

Reason for Referral:
❑ Personal Development ❑ Recommended by a Family Member ❑ Court/Lawyer Recommended ❑ Court-Mandated ❑ Other _____

Consent to Disclose Information to Legal Representative:
I _____ give consent to New Perspectives to attendance information and Letter of Completion to the following legal representative:
Name of Legal Representative: _____ **Position:** _____
Firm Name: _____ **Contact Person:** _____
Address: _____ **City:** _____ **Prov** _____ **Postal Code** _____
Phone: _____ **Fax:** _____ **Email:** _____
Signature of Client: _____ **Date:** _____

INSURANCE INFORMATION

Do you have Extended Health Care Benefit Coverage (EHC)? ❑ Y or ❑ N Insurance Provider _____

Annual Coverage Amount/per Session Rate: _____ Max # of Sessions: _____

Is your EHC based on a calendar year? ❑ Y or ❑ N , If no, Specify EHC annual reset date: _____

NOTES/ADDITIONAL INFORMATION

_____
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CANCELLATION POLICY

Please be mindful that our appointments are scheduled especially for you, therefore we kindly ask you provide us with 24hr – 48hr advanced notice if you intend to cancel your appointment with us. Unfortunately if we do not receive 24hr notice for cancelled appointment, the FULL FEE for your appointment will be required.

PLEASE NOTE OUR ACCOUNTS DEPARTMENT WILL AUTOMATICALLY SEND YOU AN INVOICE IF YOU WERE UNABLE TO CANCEL YOUR APPOINTMENT IN A TIMELY MANNER.