Solace Psychology
#204, 236 – 91 Street SW
Edmonton, AB T6X 1W8
780-702-1079
hello@solacepsych.ca

Client Information Form

Welcome. I look forward to working with you. This form requests information about you and/or your family that will help me plan your care. Please complete this form as best as you can and email it to hello@solacepsych.ca or bring it with you to your first session. If you have any questions, we will discuss these when you come in.

Date: _____ **Type of Therapy:** ☐ **Individual** ☐ **Couple** ☐ **Family** ☐ **Group**

CLIENT INFORMATION

First Name: _____ **Preferred Name:** _____

Last Name: _____ **Gender:** ☐ Male ☐ Female ☐ Other _____

Date of Birth: _____ **Preferred Pronoun:** _____ **Age:** _____

Religion: _____ **Ethnicity:** _____

Address: _____

City/Town: _____ **Province:** _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Best form of communication to confirm appointments: ☐ Call ☐ Text ☐ Email

We can leave confidential messages on: ☐ Home Phone ☐ Cell Phone ☐ Other _____

Marital Status: ☐ Single ☐ Dating ☐ Common Law ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____

Current Partner's Name: _____ **Age:** _____

Occupation: _____ **Length of Relationship:** _____

Children: Specify relationship (if biological, foster, adopted, or step-child)

NAME	AGE	GENDER	RELATIONSHIP	LIVES WITH

People living in current household other than children:

_____ **Relationship:** _____

_____ **Relationship:** _____

_____ **Relationship:** _____

_____ **Relationship:** _____

_____ **Relationship:** _____

EMPLOYMENT & ACCADEMIC INFORMATION

Employment Status: ☐ Employed ☐ Stress/Medical Leave ☐ Unemployed ☐ Retired

Occupation: _____ **Company:** _____

Are you satisfied with your current position? ☐ Yes ☐ No

Completed Education: _____

Are you satisfied with your level of education? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name: _____ **Phone:** _____

Relationship to Client: _____

HEALTH & MEDICAL INFORMATION

Are you receiving regular care from a physician? ☐ Yes ☐ No **Name of Physician:** _____

Are you receiving regular care from a psychiatrist? ☐ Yes ☐ No **Name of Psychiatrist:** _____

Date of most recent medical check-up appointment: _____

List of medical problems: _____

_____

Have you had a significant head injury? ☐ Yes ☐ No **Explain:** _____

List of current medications:

MEDICATION	PURPOSE	DOSAGE

FAMILY HISTORY

Has anyone in your family had a mental illness? ☐ Yes ☐ No

Has anyone in your family ever attempted or committed suicide? ☐ Yes ☐ No

Does anyone in your family have a substance abuse problem? ☐ Yes ☐ No

If yes to any of the above, briefly explain: _____

_____

FUNDING INFORMATION

Are your sessions being funded by a third party (i.e., extended health benefits)? ☐ Yes ☐ No

If yes, plan member's name: _____ **Funding amount:** _____

Funding company: _____ **Group #:** _____ **ID #:** _____

PSYCHOLOGICAL SERVICES

How did you hear about Solace Psychology? _____

Have you been to therapy before? ☐ Yes ☐ No

Type of therapy: ☐ Individual ☐ Couple ☐ Family ☐ Group ☐ Inpatient Program ☐ Outpatient Program

If yes, name of psychologist & company: _____ **Year:** _____

Reason for previous therapy: _____

Have you been hospitalized for mental health reasons before? ☐ Yes ☐ No **Year:** _____

Reason for hospitalization: _____

Have you been diagnosed with a mental illness? ☐ Yes ☐ No **Explain:** _____

_____

Have you had any thoughts of hurting yourself (self-harm) or another person? ☐ Yes ☐ No

Explain: _____

Have you had suicidal thoughts or intended to end your life? ☐ Yes ☐ No

Explain: _____

Most recent time you've had these thoughts: _____

Reasons for not acting on those thoughts: _____

REASONS FOR SEEKING THERAPY NOW *(check all that apply):*

☐ Anxiety	☐ Relationship Issues	☐ Chronic Pain	☐ Traumatic Event
☐ Depression	☐ Parenting	☐ Sleep Issues	○ Accident
☐ Stress	☐ Family Issues	☐ Anger/Aggression	○ Abuse/Neglect
☐ Life Balance	☐ Addiction/Substance Use	☐ ADHD	○ Significant Loss
☐ Life Changes	☐ Grief & Loss	☐ OCD	○ Natural Disaster
☐ Career	☐ Self-Esteem	☐ Learning Disorder	○ Other Trauma
☐ Body Image Issues	☐ Eating Issues	☐ Schizophrenia/Psychosis	

☐ Other: _____

_____

When did these problems start? _____

_____

How severe would you consider your issues? ☐ Mild ☐ Moderate ☐ Bad ☐ Severe ☐ Crisis

How solvable do you think your issues are? ☐ Not at all ☐ A Bit ☐ Moderate ☐ A lot

How motivated are you to work on your issues? ☐ Not at all ☐ A Bit ☐ Moderate ☐ A lot

PERSONAL RESOURCES & SUPPORTS that help you cope *(check all that apply):*

☐ Motivated	☐ Smart	☐ Pets	☐ Hobbies	☐ Journaling
☐ Funny	☐ Athletic	☐ Friends	☐ Yoga	☐ Reading
☐ Spiritual	☐ Creative	☐ Family	☐ Meditation	☐ Nature
☐ Empathetic	☐ Insightful	☐ Mentor/Sponsor	☐ Exercise	☐ Sports
☐ Kind	☐ Social	☐ Team	☐ Music	☐ Art

☐ Other: _____

Goals for therapy:

1) _____

2) _____

3) _____

4) _____

Anything else that is important for your psychologist to know:

_____

_____

_____

_____

ADDITIONAL INFORMATION

Are you required by a court of law to receive counselling as part of a legal proceeding? ☐ Yes ☐ No

If yes, please briefly explain: _____

_____

_____

Have you ever been arrested? ☐ Yes ☐ No **Year:** _____

Explain: _____

_____

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Agreement for Therapy and Informed Consent

Welcome. Thank you for choosing me, Vanessa Goodchild, to help you with your healing journey. Engaging in therapy can provide you with the opportunity to gain valuable insight about yourself and develop the necessary coping skills needed to achieve your unique goals. Before our first session, it is important that you carefully read and sign this document. Please feel free to ask any questions.

About the Psychologist

I am a Registered Psychologist in good standing with the College of Alberta Psychologists (License #5402). I hold a Master of Counselling degree from City University of Seattle and a Bachelor of Science degree with Specialization in Psychology from the University of Alberta. In addition, I have specialized training in various types of therapeutic interventions. Throughout my career I have had the great pleasure of supporting children, adults, and families impacted by mental health issues, trauma, addiction, emotional regulation, challenging relationships, life transitions (including returning to work), grief, and loss. My experience consists of individual, couple, family, and group therapy.

What to Expect from Therapy

I know that at times life can be messy and overwhelming, leaving us feeling stuck, confused, or hopeless. I offer a person-centered, respectful, nonjudgmental, and effective approach to therapy, helping you make sense of the difficulties you may be encountering in your life. We will work together to discuss your goals for therapy and develop a plan that accommodates your individual needs. Therapy is a collaborative process that requires open, honest and ongoing communication between the therapist and client. I may draw from a variety of evidence-based therapeutic modalities, including Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Eye Movement Desensitization Reprocessing (EMDR), Emotionally Focused Therapy (EFT), and Mindfulness Based Therapy. We will determine the number of therapy sessions based on your goals, progress, finances, etc.

Benefits and Risks of Therapy

Engaging in therapy can help with:

- Improved personal relationships
- Boost in self-confidence and self-acceptance
- Discontinuance of unhealthy behaviours
- Reduced feelings of distress
- Learning new coping skills
- Gaining self-awareness and insight

Discussing deeply personal topics may result in:

- Uncomfortable feelings
- Re-experiencing painful memories
- Change in behaviour

Client Rights and Responsibilities

- Ask questions and make choices about therapy
- Choose what information to share and to what extent
- End therapy at any time or refuse a type of treatment
- Request a referral to a different therapist if you feel as though we are not a good fit

***Please provide me with relevant legal and/or medical information that pertains to your situation discussed in therapy, as well as any updates throughout the process.*

Appointments

Appointments are typically *50 minutes* in length. Please arrive on time for your sessions as your sessions begin at the scheduled times. Bookings can be made via phone at 780-702-1079 or email at hello@solacepsych.ca. You will be contacted 24-48 hours prior to your session via email and/or phone as a courtesy reminder and I ask that you confirm your appointment.

Cancellation Policy

If you are unable to attend your appointment, please cancel or reschedule at least 24 hours in advance by calling 780-702-1079 or emailing hello@solacepsych.ca. If an appointment is missed or cancelled late, you will be required to pay for the session in *full*. Your credit card will be kept on file and will be charged these fees. By signing this document, you agree to these terms. Acceptable reasons for missed appointments include becoming severely ill or experiencing a provable emergency.

Fees

*Fees are consistent with recommended rates outlined by the Psychologists' Association of Alberta.

Initial Session	$175
Individual Therapy	$200
Family & Couples Therapy	$200
Parent Consultation Session	$200
Minor (ages 6 – 17) Session	$200
Assessments	Pricing per case
Reports / Letters	Pricing per case
Missed Appointments / Late Cancellations	$200
Phone/Email Consultations	$200 per hour pro-rated in 15 minute increments.

- Fees are due in full at the time of your appointment.
- Phone/email consultations with teachers, physicians, social workers, etc. are charged in 15 minute increments.
- Acceptable payment methods: credit card, debit, cash, e-transfer, or cheque.
- Sessions may be covered through your insurance/benefit plan and certain companies can be directly billed, while others will require you to pay for sessions up front and a receipt will be provided for reimbursement. Please note that insurance companies typically do not cover missed appointment fees.

Confidentiality

All information disclosed within therapy sessions is strictly confidential. No information will be released without your explicit consent. When there is more than one client attending a session (i.e., couples, families), additional guidelines regarding confidentiality apply and will be discussed per case. Your file will be kept for a minimum of 11 years and then shredded. Electronic files will be password protected and encrypted and stored within a secure program specific for counselling notes and files. All paper files will be stored in a locked filing cabinet in a securely locked room.

The following are legal and ethical exceptions to your confidentiality, of which I would inform you if I might have to act on:

- If there is reason to believe that a child, person with a disability, an elderly adult, or animal is at imminent risk of being harmed (i.e., physically, sexually, or emotionally abused, or neglected).
- If there is reason to believe that you are at imminent risk of harming yourself or others.
- If you are in medical distress that is an emergency.
- If there is a court order or other legal situation unfolding.
- Defending a malpractice suit.
- Collecting unpaid fees, which may be forwarded to a collection agency.
- If I have an emergency replacement take over my files.

Emergencies

I am not generally available on an emergency basis. If you are experiencing an emergency related to mental health, you can access the following:

- The Distress Line (24/7): 780-482-HELP (4357)
- Community Urgent Services and Stabilization Team (24/7): 780-342-7777
- Mental Health Helpline (24/7): 1-877-303-2642
- Addiction Helpline (24/7): 1-866-332-2322
- Children's Mental Health Crisis Line: 780-427-4491
- Kid's Help Phone: 1-800-668-6868
- 911 or go to nearest Emergency Room

Consent for Services

I _____ have read and understand the above information and accept the conditions for receiving services from Vanessa Goodchild at Solace Psychology. I have been given the opportunity to address any questions, concerns, or uncertainties within this form that are unclear to me. I confirm that staff from Solace Psychology can contact me via email and/or phone to discuss my appointments. I confirm that I am signing of my own free will. I understand that I have the right to withdraw consent and/or refuse treatment at any time.

_____	_____	_____
Client's Name (Print)	Client's Signature	Date
_____	_____	_____
Psychologist's Name (Print)	Psychologist's Signature	Date

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Credit Card Pre-Authorization

I authorize Solace Psychology to keep my credit card information on file and to charge my credit card for payment of my session (individual, couple, family, parenting, group, workshop, or other) in the amount established by Solace Psychology for the following purposes:

- ✓ For a no-show, missed session, or late cancelled session (without 24 hours' notice).
- ✓ For a phone or video session.
- ✓ For past due sessions.
- ✓ For sessions that are not fully covered by a third party (i.e., insurance company).

I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session. I will be notified by my provider verbally or in an email that the session payment will be applied to my credit card.

I understand that this information is stored in a confidential and secure server and is highly unlikely to be tampered with. I agree to assume the risk if the file and credit card information is compromised.

I agree that if I have concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my psychologist at Solace Psychology for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my psychologist.

If I am assuming session payment responsibility for the client listed below, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by this person's psychologist at Solace Psychology.

I agree to update my psychologist should my credit card be cancelled or compromised, and to update my psychologist with a new credit card to keep on file.

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy.

By signing below, I certify that my information is true and accurate, that I am an authorized user on the account, and that I agree to the above terms.

Client's Name: _____

Cardholder's Name: _____ **Relationship to Client:** _____

Cardholder's Address: _____ **City:** _____

Province: _____ **Postal Code:** _____ **Phone:** _____ **Email:** _____

Card Type: ☐ Visa ☐ MasterCard

Card Number: _____ **CSC# (on back of card):** _____

Expiry Date: _____ **Signature:** _____ **Date:** _____

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Teletherapy Informed Consent

I _____ (print name) hereby consent to engage in teletherapy (i.e., internet, email or telephone-based therapy) with Vanessa Goodchild, Registered Psychologist, as a mode of psychotherapy treatment.

Definition of Teletherapy:

Teletherapy services are a form of psychological service provided via phone or internet technology. Teletherapy has the same purpose as therapy sessions that are face-to-face. Teletherapy involves arranging an appointment between the client and psychologist when both parties can connect from their phones, computers, or technological devices.

Rights in using Teletherapy Services:

✓ You have the right to withdraw consent at any time. This will not affect your right to further treatment.

✓ Confidentiality still applies for teletherapy services and nobody will record the session without the permission of the other person(s).

- Psychologists have an ethical obligation to breach confidentiality in cases of: disclosure of child, elder, dependent adult, and animal abuse; expressed threats of violence towards an identified victim; expressed grave danger toward oneself; and if subpoenaed.

By signing this document, I understand and agree to the following:

✓I agree to use the video-conferencing platform selected for our virtual sessions and my psychologist will explain how to use it.

✓I must provide my own phone, computer, or technological device for sessions.

✓It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

✓It is important to use a secure internet connection rather than public/free Wi-Fi.

✓Despite best efforts to ensure high encryption and secure technology, there is always a risk that the transmission be breached and accessed by unauthorized persons.

✓It is important to be on time. If I need to cancel or reschedule my tele-appointment, I will notify my psychologist with a minimum of 24 hours in advance by phone (780-702-1079) or email (hello@solacepsych.ca). If I do not provide 24 hours' notice, I understand that I will be charged the full session fee.

✓I take responsibility to determine if my insurance provider covers the cost of teletherapy services.

✓The psychologist has the right, at any time, to determine if teletherapy sessions are not appropriate for my case. Should this be determined, we will continue with face-to-face services or I will be provided with referral information to other services.

** *For children and teens:* I understand that I need the permission of my parents and/or guardians to participate in teletherapy.

Emergencies:

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call The Distress Line (24/7) at 780-482-HELP (4357).

Client's Name (Print)	Client's Signature	Date

If child or teen session, parents must also sign:

Parent/Guardian's Name (Print)	Parent/Guardian's Name Signature	Date
Parent/Guardian's Name (Print)	Parent/Guardian's Name Signature	Date
Psychologist's Name (Print)	Psychologist's Signature	Date