Stopping the Violence Counselling Program

FERNIE WOMEN'S RESOURCE CENTRE

By completing this intake form, you are agreeing to the following confidentiality policy. This will be reviewed with your Counsellor when you meet.

My involvement with the Stopping the Violence Program is voluntary and confidential within the limits of the law. I understand that confidential services mean that a release of any information may only happen with my written consent and that the Stopping the Violence Counsellor may not legally or ethically discuss any details of my session either personally or professionally. The following situations are exceptions:

- If the client is a risk to herself or another person;
- If the client's life is at risk;
- If a child is at risk;
- If a court order is issued for the counsellor's records, or;
- For purposes of supervision, and for case consultation within Fernie Women's Centre staff team

Date: _____

Client's Name: _____

Address: _____

Phone: _____ Okay to leave message?: Yes / No

Email: _____ Birth date: _____

Relationship Status: _____Significant Other's Name:_____

Children & Ages: _____

Occupation: _____ Referred by: _____

Which community would you prefer to receive counselling in? (you can check more than one)

☐Fernie ☐Sparwood ☐Elkford

Emergency Contact's Name: _____

Phone: _____ Relationship: _____

MEDICAL AND HEALTH INFORMATION

Family Doctor: _____

Any relevant health information: _____

_____

Are you currently taking any medication(s)? Yes No
If yes, please list:_____

Have you ever received a mental health diagnosis? Yes No
If yes, what diagnosis & when was it given? _____

Do you use alcohol or drugs to a point where you consider it to be a problem?
Yes No
Please provide details _____

Do you have extended health benefits from your current employer?
Yes No

SAFETY

Are you feeling safe in your current relationship? Yes No

Please provide details:_____

Have you had thoughts of suicide:
1) in the last month? Yes No
2) ever? Yes No

Please provide details: _____

Have you attempted to end your life:
1) in the last month? Yes No
2) ever? Yes No

Please provide details: _____

COUNSELLING HISTORY AND GOALS

Have you ever experienced any of the following traumas?

- □ Abusive relationship
- □ Divorce/separation
- □ Imprisonment/kidnapping
- □ Physical assault by someone you know
- □ Physical assault by a stranger
- □ Sexual assault by someone you know
- □ Sexual assault by a stranger
- □ Sexual contact before you were age 16 with someone significantly older (5yrs+)
- □ Stalking or harassment
- □ Abandonment in childhood
- □ Sexual abuse in childhood
- □ Physical, emotional or verbal abuse in childhood
- □ Witnessing abuse (as a child)
- □ Major loss/grief
- □ War
- □ Life-threatening illness
- □ Natural disaster
- □ Serious accident, fire or explosion
- □ Other traumatic event (please specify) _____
- □ At least one of the above, but I don't want to disclose this right now

Are you currently attending counselling with another provider? Yes No

If yes, please list: _____

Have you seen a counsellor in the past? Yes No

If yes, when and what for? _____

Did you find it helpful? Yes No
Please explain: _____

_____

Would you be interested in joining a group? Yes No

What is your main reason for seeking counselling now? _____

_____

_____

What are your 3 main goals for counselling?

1. _____
2. _____
3. _____

RESOURCES

Who do you turn to for support/help? _____

_____

When you are upset, how do you calm yourself down? _____

_____

What do you do to relax and have fun? _____

_____

What are 3 of your biggest strengths?

1. _____
2. _____
3. _____