Stopping the Violence Counselling Program

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: _______________________

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. ______________________________