DR. JOAN M.C. HILLSON PSYCHOLOGICAL SERVICES

INTAKE FORM

NAME(S):____

DATE(S) OF BIRTH:____

ADDRESS:____

EMAIL ADDRESS:____

PHONE NUMBERS:___________________________ msg okay Y/N please circle

___________________________ msg okay Y/N please circle

___________________________ msg okay Y/N please circle

EMERGENCY CONTACT:____

(name) (phone) (relationship)

FAMILY DOCTOR:____

(name) (phone)

CURRENT MEDICATIONS (including dosages):

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PREVIOUS THERAPIST OR COUNSELLOR (if applicable. Contact will only be made with your consent, which is entirely voluntary.)

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(name) (phone, if known)

Are your psychological symptoms work related? ☐ Yes ☐ No

If "yes", have you missed more than one day of work due to these symptoms? ☐ Yes ☐ No

PAYMENT

FEE: $200/50 minute session. Please check your preferred method of payment and include insurance information if applicable:

- ☐ Blue Cross (direct bill) Group #______________ ID#_____________________________
- ☐ Green Shield (direct bill) ID#____
- ☐ RCMP (direct bill) # R00____
- ☐ VAC (direct bill) ID# K____
- ☐ Great West Life (direct bill) ____
- ☐ Other ____
- ☐ e-transfer
- ☐ Cheque (NSF fees will apply for returned cheques)
- ☐ Cash

***Any amount not covered by your insurance provider will be payable at the end of your session and a receipt will be provided.**

PRESENTING ISSUES

In your own words, please indicate what struggles you are experiencing and/or what you are looking for help with. Thank you.

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Client Signature(s) Date