Clients Intake and Psychosocial Assessment

Day Treatment Program

Name:____________________ M/F (circle one)

DOB:_____________________

Date of Attendance:____

Email Address:____

Mailing Address:____

Phone number:____

Emergency Contact:____________________ Phone#:______________

Marital Status:________________________

Are you in a relationship currently? Y or N (circle one)

Who referred you to this program?______________________________________

Any history of substance abuse? Choice of drug:

____

____

Do you drink more than once per week? If so, how often?

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____

How often do you use recreational drugs?

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____

Are you currently on prescription medications? ◯ Yes ◯ No
if yes please list:

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____

Please identify any health concerns and or conditions

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Have you ever experienced any physical, mental, or emotional abuse?

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Have you ever experienced any stressful events that have changed your life significantly?

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What are your weaknesses?

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____

What are your strengths?

____

____

Have you ever tried to stop using before? When and Why?

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Please identify your support system:

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What made you want to take this program?

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What do you want to accomplish with the time spent in this program?

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Any additional information that we should know to help you through this healing journey?

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CONSENT TO SERVICES & CONFIDENTIALITY AGREEMENT

Our Goals: The goal of Mental Health and Addictions (MH&A) is to provide counselling services that will respect your values and offer you a variety of approaches to improve the well-being of you/your family. In the process, you/your family have the right to the confidentiality of all the information you share with our staff, and the right to view all records that relate to you/your family.

The Process: In most cases, our staff will spend some sessions gathering information about your situation. After this, our staff will let you know what they think might help in your situation, and how this help might best be delivered to you and your family. * You/your family have the right to know exactly what is happening at any time in the process, and where you are at in the process. Your participation is voluntary, and you may terminate your involvement at any time.

The Records: In order to view your records, a written request must be made to the Manager of this program (MH&A). Your records will be revealed to you once we are assured that all the people listed in the records are protected.

Confidentiality: We follow a confidentiality protocol; however, there are some times when we have to reveal the information in your records to other people. Here are some examples of when we have to tell others about your situation:

- If anyone expresses a desire of harming themselves or someone else, and our staff believe that there is a real danger of someone being harmed, we have to let the proper authorities know;
- If someone discloses that a child/youth (under the age of 19) is or has been physically, sexually, emotionally abused or neglected, we have to let others know;
- In rare cases a judge may ask to see your records for court purposes.

Understanding: It is important to us that you/your family members understand the reasons for anything that happens during the time we spend with you. We invite you to ask any questions about any issue at any time.

Verbal Consent/Signed Consent below, we/I agree that we/I understand the above issues and agree to participate in services.

Parents/Guardians/Family Members/Individual(s)

○ **Verbal Consent Given** ○ **Verbal Consent Not Given**

______________________	______________________
Name	Signature
______________________	______________________
Name	Signature
______________________	______________________
MH&A Clinician Name	Signature

Date:______________________