Barrhaven Psychological Services
New Client Questionnaire

Client Name: _____ Date: _____

Client Preferred Name: _____ Gender: _____

Address: _____

City: _____Postal Code: _____

Home phone: _____Work:_____Cell:_____

Email: _____

Age: _____Birth Date: _____

Occupation (If applicable): _____

Relationship status: ❒ single ❒ married ❒ common-law ❒ separated ❒ divorced ❒ n/a

Number of children: _____ Age of children: _____

Parent information to be completed if client is 18 years old or younger:

Parent/Guardian 1 name: _____ Contact #:_____

Parent/Guardian 1 occupation: _____

Parent/Guardian 2 name: _____ Contact #:_____

Parent/Guardian 2 occupation: _____

Custody arrangement: _____

Grade: _____School:_____

Doctor's Information:

Who referred you? _____ ❒ I was self-referred

Family physician? _____

Location of your physician's office: _____

What kind of counselling or psychotherapy have you (or your child) had in the past?

_____

List any medications you (or your child) are currently taking:

_____

List any major health problems you (or your child) are dealing with:

_____

Briefly state your reasons for seeking help:

At what times over the course of your life have you dealt with mental illness/mental health difficulties?

From _____ to _____ What were you dealing with? _____

From _____ to _____ What were you dealing with? _____

From _____ to _____ What were you dealing with? _____

At what age did your mental health difficulties first begin? _____

When was the last time that you were symptom free or felt like your usual self? _____

_____

Authorization to update your physician:

We would like to be able to provide your physician with a summary about the nature of your difficulties and about your progress once we have started. If you would like us to update your physician, place check "Yes", and check off the psychologist's name that you are receiving services from and then sign your name and date to signify that you have authorized us to release this information to your physician. This authorization is valid for the following 12 months.

Please complete below:

☐ Yes, I would like the information provided to the following: **(please check one below)** to be released to my physician (named on page 1 of this form).

Dr. Darcy Santor ☐ Dr. Lindsay Rosval ☐ _____ ☐

Dr. Lisa Alli ☐ Dr. Amélie Beausoleil ☐

Signature **Date**

Signature Guardian (if applicable) **Date**

Our Cancellation/Rescheduled/Missed appointment policy:

In case of an unexpected situation where you may not be able to attend your scheduled appointment, we require **48 hours (2 working/business days - Saturday and Sunday DO NOT APPLY) notice.** The policy of the clinic is to charge a cancellation fee of $100.00 if the appointment is cancelled less than the 48 hours notice. We try to be flexible in applying the cancellation fee, understanding that emergencies and extenuating circumstances do arise. However, a last-minute cancellation is a concern, and a lost opportunity, for which we apply a fee. Cancellations in and of themselves are never an issue. With sufficient notice we would be able to re-allocate a canceled appointment with a couple of days notice. We have clients who are currently waiting 8 to 10 weeks if not longer, for an appointment, who would be grateful for an appointment. Unfortunately, we are unable to do this on short notice, therefore, any late cancellations (not within the 48-hour notice) and NO SHOWs will have a $100 fee applied.