Kevin Richardson MSW, RSW,
Counselling and Psychotherapy Services, 34 Carlton St; Winnipeg, MB, R3C 1N9
www.mywinnipegtherapist.ca

CLIENT INFORMATION

Date: _____

This information is confidential and will be used by your counsellor to assist you. Mom or Dad can help you fill this out. In most cases, counsellors will not give information you shared in session to your parents unless you give permission.

Name_____Date of Birth_____

How Did you hear about us? (Circle one of the following)

1-Psychology Today 2-Theravive 3-Birch Wellness Website

4-My Winnipeg Therapist Website 4-Word of Mouth 5-Other_____

What grade are you in? _____

How do you feel at school? (circle on of words below)

very happy—-happy—- average—- unhappy—- very unhappy

How are you doing at school?

very well—-good—- ok—- could be doing better—not doing very well

FAMILY INFORMATION

Mom and Dad's names (or guardians):

_____

Brothers and sisters? Names and ages

_____

_____

How do you feel at home *(Circle one)*

very happy—-happy —-average—-unhappy—-very unhappy

MEDICAL INFORMATION

List any present health problems, major surgeries, injuries (with dates)

_____

_____

Date of last medical check-up _____
Reason_____

Family Physician_____

Are you taking medication now? _____

Name(s) of your medication

_____

PSYCHOLOGICAL INFORMATION

List any significant crises, losses or stressors

_____

_____

_____

What problems or concerns would you like help with?

_____

_____

_____

What's the biggest thing that bugs you or gets up upset?

_____

_____

What would it be like if these things that bug you disappeared?

_____

_____

What do you do for fun? What are your interests?

_____

_____

What makes you feel the happiest?

_____

_____

For ADDITIONAL COMMENTS please write on reverse side

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Parental Consent

Please check the one that applies to you:

Both parents share custody and either parent can give consent: ____

One Parent has sole custody who can give consent : _____

One parent has sole custody but both can give consent: _____

Parents Contact Info:

Parent 1 Name: _____Date of Birth_____

Parent 2 Name : _____Date of Birth_____

Address_____ City _____ Postal Code_____

Do not include phone numbers and email addresses that you do not wish me to contact you at.

Who is the main Parent contact: _____

Home phone _____ Cell_____

email: _____

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CONSENT TO TREATMENT

The undersigned client agrees to undertake mental health treatment with Kevin Richardson MSW, RSW. Treatment may be in the form of consultation, mental health treatment or psychotherapy. There are many different methods of treatment that I may use to address the problems that you wish to discuss with me. Participating in psychotherapy can result in various benefits to you, including: developing personal insight; reducing emotional distress; increasing your capacity for intimacy; and resolving other specific concerns. Psychotherapy can have risks as well. During the course of therapy you may experience uncomfortable feelings or you may experience unexpected consequences. Psychotherapy requires openness and your active involvement. You are encouraged to give me feedback and input about the course of your therapy as it proceeds. While success cannot be guaranteed, therapist and client join together in a good faith interest in meeting the goals of the client.

FEE AND CANCELLATION POLICY

1. The fee is for a 50 minute session (10 minutes notes). Payment is expected at the time of your session, unless otherwise arranged.
2. *Cancelations:
    a. There is no charge for a cancellation made at least 24 hours before the time of an appointment.
    b. Late Cancelations are charged full session fee.
3. My services may be covered by many third-party health insurance policies. Receipts for reimbursement from insurers are provided.
4. My services are tax-deductible – please keep your receipts.
5. Telephone calls exceeding 10 minutes, other than the initial consultation, will be billed proportionately; as will professional telephone consultations (e.g. physicians, school staff, lawyers) exceeding ten minutes. These services will be billed proportionately at the hourly rate and undertaken only with your explicit consent.

1. Written reports to other professionals or third-parties (e.g. insurance, government agencies) will be billed proportionately at the hourly rate and undertaken only with your explicit consent.

I HAVE READ THE ABOVE AND I AGREE TO THE TERMS AS OUTLINED.

_____ _____

CLIENT SIGNATURE DATE

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Credit Card Payment Consent Form

Patient Name:_____
(Please Print) *Last Name* *First Name* *Middle Initial*

Name on Card (if different): _____

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express

Credit Card Number _____ Expiration Date_____

CVV Number _____ *A 3-digit number in reverse italicson the **back** of the credit card.*

I authorize Kevin Richardson, and Birch Wellness Center, to charge my credit/debit card for professional services as follows
Please Initial

____ After each counselling session

____ Once per month

_____All visits in the next 12 months, beginning __/__ /__ , not to exceed $_____ total.

Card holder Signature _____Date____ /_____ /____

*Charges will appear on your credit card as **Birch Wellness Center** or **Kevin Richardson MSW, RSW**.*

Thank you for completing this form!