INTEGRATE
HEALTH SERVICES

Adult General Services Intake

Date: _____ How did you hear about us? _____

What service(s) are you interested in? _____

CLIENT INFORMATION:

Name: _____

Date of Birth: _____ (Age) _____ Gender: Male: _____ Female: _____

Address: _____ City: _____ Postal Code: _____

Main contact # ( ) _____ Alternate # ( ) _____

Email * (We will use email for important correspondence): _____

***Please add me to your mail list so that I receive information about programs and services*:** ☐ **Yes** ☐ **No**

Marital Status:

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: _____ or ☐ Single

Have you been married before? *If yes, indicate date(s):* _____

Do you have a mental health diagnosis or concern? _____

Do you have a family history of mental or physical health concerns? _____

Do you have any significant physical health problems? _____

What is your profession? _____ Are you currently working? ☐ Yes ☐ No

What is your profession? _____ Are you currently working? ☐ Yes ☐ No

Complete if you are currently a student:

School name: _____ Grade/Year: _____

☐ University ☐ College ☐ High School ☐ Trade ☐ Other: _____

Program (if applicable): _____ ☐ Part-time student ☐ Full-time student

Children or Dependants: (please indicate whether biological, step, adoptive, foster)

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

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Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Who lives in your household? _____

_____

CLIENT INFORMATION: (please complete if interested in couples or family counselling)

Name: _____

Date of Birth: _____ (Age) _____ Gender: Male: _____ Female: _____

Please describe relationship to client (Client 1) _____

Address is same as above? ☐ Yes ☐ No OR

Address: _____ City: _____ Postal Code: _____

Main contact # ( ) _____ Alternate # ( ) _____

Email * (We will use email for important correspondence): _____

***Please add me to your mail list so that I receive information about programs and services*: ☐ Yes ☐ No**

Marital Status:

☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed -Please indicate date: _____ or ☐ Single

Have you been married before? *If yes, indicate date(s):* _____

Do you have a mental health diagnosis or concern? _____

Do you have a family history of mental or physical health concerns? _____

Do you have any significant physical health problems? _____

What is your profession? _____ Are you currently working? ☐ Yes ☐ No

If so, please provide hours of work: _____ Longest term employed? _____

Complete if you are currently a student:

School name: _____ Grade/Year: _____

Type of school (university, high school, college, etc.): _____

Program (if applicable): _____ ☐ Part-time student ☐ Full-time student

Children or Dependents: (please indicate whether biological, step, adoptive, foster)

☐ Check here if same as above

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Name: _____Nature of relationship: _____ ☐ M ☐ F D.O.B _____

Who lives in your household? ☐ Check here if same as above

_____

_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Main contact # ( ) _____ Alternate # ( ) _____

IMPORTANT INFORMATION:

Please list all individuals who may be accessing services: (Complete if applicable)

What are your primary concerns and frequency of concerns?

Please describe any stressors/ triggers:

What have you tried to resolve these difficulties? (Please indicate what worked and what didn't work)

Please summarize any current/ past involvement with any community organizations/ counselling or therapeutic services. Was it helpful? What was helpful?

What are your service goals? (what are hoping for at the end of treatment?)

INFORMED CONSENT

Thank you for your interest in Integrate Health Services. Please be aware that all client information will be stored as confidential clinic records. Where assessment services are provided, information shared will become part of a consult letter, which will be forwarded to the client and referring physician. Any additional information shared outside the clinic would require the written permission of the client.

CONFIDENTIALITY:

There are by law, certain circumstances in which confidentiality cannot be maintained.
These situations would include: (1) suspected child abuse or neglect (2) circumstances where the client has become a danger to themselves or others, (3) when information has been subpoenaed by the court. Should you have any questions about the limits of confidentiality, please contact an Integrate Health Services team member.

APPOINTMENTS:

Please ensure you arrive on time for your scheduled appointment, as we are unable to extend your session time. No show appointments will be subject to a full session charge.

INTEGRATE HEALTH SERVICES TEAM APPROACH- CIRCLE OF CARE:

Integrate Health Services is a multi-disciplinary team working in partnership with Kids Clinic. We are comprised of various health professionals and in circumstances where it is believed to be in the best interest of the client, please be aware that personal health information may be shared among healthcare providers at Integrate Health Services and Kids Clinic. Information shared will be determined on a case-by-case basis dependant upon the needs of the individual client(s). *When you access speech therapy services, please be aware that the information you provide to Integrate Health Services or Kids Clinic is shared with our partner Speech Therapy Centres of Canada. By signing this form, you are consenting to all services provided through Integrate Health Services or Kids Clinic, including those affiliated with Speech Therapy Centres of Canada and understand that the same limits of confidentiality apply.

Integrate Health Services provides the following support programs and services:

- *Psychological Assessments*
- *Counselling Services*
- *Art Therapy*
- *Applied Behaviour Analysis/Intensive Behavioural Intervention*
- *Behaviour Consultation*
- *Child/Youth/Adolescent Group Programs*
- *Parent Support and Education*
- *Education Services*
- *Occupational Therapy*
- *Speech and Language Therapy (through partnership with Speech Therapy Centres of Canada)*
- *Naturopathic Services*
- *Medical Assessment and Treatment services (by referral only through partnership with Kids Clinic)*

CLIENT CONSENT:

I, _____ have reviewed the above information and fully understand the details of informed consent. An Integrate Health Services team member has answered any questions I had. At this time, I make an informed choice to access services at Integrate Health Services.

_____	_____	_____
Client 1 Name/Signature	Signature	Date
_____	_____	_____
Client 2 Name/Signature	Signature	Date

INTEGRATE
HEALTH SERVICES

APPOINTMENT CANCELLATION POLICY

1. Our policy is 24-hour (1 business day) cancellation for all scheduled appointments. For example, if your appointment is scheduled for Monday at 10 a.m., you must cancel the appointment no later than 10 a.m. the Friday before the appointment. If the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Tuesday at 2 p.m.

* Missed appointments without any prior notice may be subject to a cancellation fee up to a full session charge. **This fee cannot be billed to a third party funder or grant and must be paid directly by the client.**

2. To cancel an appointment, please call 905-683-7228.

If you cannot reach us in person or by phone, you may leave a detailed voice message with your name, date and time of your scheduled appointment and your request to cancel or reschedule.

I, _____ and _____ have reviewed and agree to the above stated policy regarding appointment cancellation.

_____ _____
Client 1 Signature Date

_____ _____ _____
Client 2 Signature Signature Date

_____ _____ _____
Witness Name Witness Signature Date