CONFIDENTIALITY AND PERMISSION FORM

I am aware that Carolyn Waddell is a Registered Psychotherapist, and that everything that is discussed in counselling is confidential. I am aware that this confidentiality extends to all issues except those which Carolyn Waddell is required by law to report, such as suspicion of abuse to a minor child or vulnerable person, danger of suicide, actual current suicide attempts, threats to the life of another person, misconduct by a regulated health professional, or release of information ordered by a court of law.

I am aware that Carolyn Waddell works with a team, for my benefit and her own support and accountability. I am also aware that the limited information shared with team members is completely confidential between the people involved.

Therefore, I, _____, give my permission to Carolyn Waddell to discuss information from my sessions with her supervisor and/or professional support group. I understand that if I wish my information to be shared with my health care team and/or other support people, additional release of information forms will need to be signed, where applicable.

I am also aware that all matters of confidentiality and professional ethics will be respected in the counselling, supervisory and information sharing process. I agree to enter counselling with Carolyn Waddell within these guidelines. I am aware that I may withdraw my consent to counselling at any time.

Client's Signature _____ Date _____

Client's Signature _____ Date _____

Counsellor's Signature_____ Date _____

REGISTRATION FORM DATE-

NAME	
ADDRESS	
TOWN/CITY	
PROVINCE/TERRITORY/STATE	
COUNTRY	
POSTAL CODE/ZIP	
PHONE	
EMAIL	

Birthdate (day, month, year)-

Occupation-

What social, emotional, spiritual supports do you currently have? (eg. family, friends, community and/or church involvement, spirituality, personal coping skills, recreational outlets, etc.)

Are you currently receiving or have you had previous counselling?

□-No

□-Yes
If yes, please give further details.

Please briefly state the reason(s) you are seeking counselling.

RISK ASSESSMENT

Do you ever take action to harm yourself in any way?

□-No

□-Yes
If yes, please state what you do.

Are you considering attempting suicide?

□-No

□-Yes

Suicide Risk (check all that apply)

□-I have dark thoughts, but I would not take action to harm myself.

□-I have thoughts of harming myself, and think about ways to do this.

□-I am not currently having suicidal thoughts.

□-I have had suicidal thoughts in the past.

□-I have attempted suicide before.

□-I do not believe that suicide is an option no matter how badly I feel.

□-I have never thought of suicide.

PLEASE NOTE:
IF EVER YOU ARE SUICIDAL, YOU NEED TO ACCESS EMERGENCY SUPPORT IMMEDIATELY, NOT WAIT FOR A COUNSELLING APPOINTMENT. DIAL 911 (in North America) OR GO TO YOUR LOCAL HOSPITAL EMERGENCY ROOM.

Do you smoke, drink alcohol, or use drugs? If yes, please state what substance you use, how much, and how often.

Do you have any current medical conditions or illnesses? If yes, please specify.

Please list medications you are taking.

SYMPTOM CHECKLIST

Please check the conditions that apply to you:

□-Headaches
□-Dizziness
□-Fainting spells
□-Palpitations
□-Stomach trouble
□-No appetite
□-Fatigue
□-Insomnia
□-Nightmares
□-Dreams
□-Anxiety
□-Tense
□-Feel panic
□-Depressed
□-Suicidal thoughts
□-Sexual problems
□-Unable to make decisions
□-Shy
□-Lonely
□-Marital problems
□-Can't keep a job
□-Inferiority
□-Outburst of tears
□-Anger
□-Jealous
□-Fear
□-Rejection
□-Financial problems
□-Other (please describe any other symptoms not listed here)

What do you think life would be like for you, if things were to improve in your situation?

Other Notes: