

# INSTRUCTIONS FOR ENCLOSED FORMS

## 1. CONSENT FORMS

There are two consent forms. One is called “Informed Consent and Authorization for Services.” This is a summary of information about Cobb Counselling & Consulting. It answers many common questions about confidentiality, fees, and frequency of visits. The other is called “Consent to be Contacted” and is for specifying how you would like to be contacted in the future by Cobb Counselling & Consulting.

Please read through both forms, mark the appropriate boxes where indicated, and sign the bottom of each form. Bring these forms with you to your initial session. Feel free to discuss any questions with your therapist before signing them.

Only one of each form is necessary per couple or family.

## 2. INTAKE QUESTIONNAIRE

The purpose of this questionnaire is to aid assessment and treatment planning by giving your clinician a broad overview of your background and current situation at a glance. All information you provide in this form will be kept as part of your confidential file. Please read each question carefully, write your answers in the spaces provided, and bring the completed form with you to the first session. It will take about 5-10 minutes to finish. If you are coming as a couple, each of you should fill one out.

This questionnaire is not required but it is strongly encouraged as it is very helpful to the assessment if completed ahead of time.

If you have any questions, please do not hesitate to telephone or email.

# CONSENT TO BE CONTACTED

Some verbal and written communication from me to you is necessary from time to time so that I can provide services to you and operate the business side of my practice. Examples include: scheduling appointments, collecting payments, reminders about upcoming appointments, and follow-up to services being provided. Every effort is made, however, to be discrete in contacting you.

This form allows you to specify some of the purposes and methods of contact that you are comfortable receiving from me. Every reasonable effort will be made to limit contact to the methods you select. This consent is specifically for contact I initiate with you (i.e. follow-up, reminders, letters, invoices, etc.)

**CHECK →** Please check your preferred method(s) of receiving written communication initiated by Cobb Counselling & Consulting: *Mail*  *Fax*  *Email*  *Any*

Special Instructions (if any): \_\_\_\_\_

**CHECK →** Please check whether you would like to receive newsletters and notices of new services or upcoming events. *Yes, By Mail*  *Yes, By Email*  *No*

**CHECK →** Please check whether you are willing to complete a client satisfaction survey giving feedback about the quality of services offered up to 6 months post-treatment? *Yes, By Mail*  *Yes, By Email*  *No*

## Your Contact Information

Mailing Address: \_\_\_\_\_  
Street Address City Province Postal Code

Phone: Home \_\_\_\_\_ May a message be left at this number? Yes  No

Work \_\_\_\_\_ Whose number? \_\_\_\_\_ May messages be left? Yes  No

Cell \_\_\_\_\_ Whose number? \_\_\_\_\_ May messages be left? Yes  No

Cell \_\_\_\_\_ Whose number? \_\_\_\_\_ May messages be left? Yes  No

Fax \_\_\_\_\_ Is this a confidential fax? Yes  No

Special Instructions: \_\_\_\_\_

Email Address: \_\_\_\_\_  
(Provide if you wish to receive correspondence from me by email, as indicated in your selections above).

## YOUR SIGNATURE

I/we give our authorization to be contacted by Cobb Counselling & Consulting as outlined above.

\_\_\_\_\_  
Name Signature Date

\_\_\_\_\_  
Name Signature Date

# INFORMED CONSENT

## AND AUTHORIZATION FOR SERVICES

**Welcome to Cobb Counseling & Consulting. This form provides information to help you make an informed decision about accepting services from me.**

### My Qualifications

- Ph.D. and M.S. in Marriage & Family Therapy from Brigham Young University
- B.A in Psychology from the University of Calgary
- Registered Psychologist with the College of Alberta Psychologists
- Clinical Member of the American Association for Marriage & Family Therapists
- Listed on the Registry of Marriage and Family Therapists in Canada

### Frequency of Sessions

- Weekly or bi-weekly 50-minute sessions are most common.
- Frequency of sessions is based largely on your needs and situation.

### How Long is Therapy?

- I usually work within a short-term model of therapy (i.e. 1-20+ sessions).
- The amount of sessions needed varies depending on the nature of each person's concerns, the complexity of the issues involved, the strength of our working relationship, and each person's commitment to work on the presenting issues. There is a direct relationship between effort applied between sessions and progress over time.

### Fees

- **\$160 per 50-minute hour**
- I prefer payment at each session rather than a regular billing process.
- Additional time beyond the 50-minute hour is billed in 10-minute increments.
- Billable services include: face-to-face and telephone consultations (not including the initial intake or dealing with brief scheduling matters), report writing, and review of written records from other professionals.

### About Privacy

- **All information you share with me is private and confidential.**
- **I will not release your information to anyone without your written permission.**
- If any information is to be released I will consult with you about what is released.
- Your information will be kept on file in a secure and private location.
- You may review the contents of your own counseling file upon request.
- The full privacy policy for Cobb Counselling & Consulting is available upon request. It can also be viewed at [www.nathancobb.com/privacy-policy.html](http://www.nathancobb.com/privacy-policy.html)

### Exceptions to Privacy

**Your confidential information may be released without your consent under the following conditions:**

- When the purpose is to protect individuals (including a client) who are at foreseeable and imminent risk of bodily harm or death as a result of a client's actions.
- Under law that requires reporting of child and elder abuse/neglect to authorities.
- Under subpoena from a court of law.
- There are exceptions that apply to personal information disclosed by minors. I will discuss these with you in session, as applicable.

### Email Privacy

- Email is a quick and convenient method of communication. Many of my clients use it to correspond with me. Please be aware, however, that while every effort is made to safeguard your privacy, I cannot guarantee the confidentiality of email correspondence.
- If this is a concern for you, please do not send me email.
- I will only use email to communicate with you: a) in response to an email you send me, or b) as you authorize it or otherwise request it.

**Consent to Release Information to Health Insurance Provider**

**Skip this section if you do not plan to submit claim to your health insurance provider**

I understand that my insurance company \_\_\_\_\_  
Name of company  
 may contact Cobb Counselling & Consulting to obtain information necessary to verify my claim for reimbursement. I understand that the type of information requested would typically include: 1) date of service, 2) the nature of services provided, and 3) the individuals who received the service. It may also include diagnosis and treatment plan information.

I give my consent to Cobb Counselling & Consulting to release to my extended health insurance provider information that is necessary for processing of my insurance claim.

**Initial Here →**

\_\_\_\_\_ or  Does not apply to me/us  
Initials Initials

**24-Hour Cancellation Policy**

- If you cannot attend an appointment, please let me know 24 hours in advance.
- There is a charge for missed appointments and for late-cancelled appointments.
- The purpose of a cancellation policy is to allow me enough time to fill the appointment. I appreciate that unforeseen events sometimes happen, but please be as respectful of my time as you can. The decision to bill is at the discretion of the therapist.
- Please cancel by telephone since email delivery is not always instantaneous or reliable.
- If you arrive late, the session will have to be shorter.
- If you are more than 20 minutes late, I will assume you are not attending.

**Initial Here →**

*I am aware of and agree to pay the late cancellation/missed appointment fee in the event that I cancel an appointment with less than 24 hours notice. I am aware that the charge is \$80.00* \_\_\_\_\_  
Initials

**Initial Here →**

*I understand that a notification to cancel initiated after hours (i.e. after 4:30PM or on weekends) for an appointment scheduled the following business day is considered a late cancellation regardless of the length of notice.* \_\_\_\_\_  
Initials

**Emergencies**

- If your life or safety is in danger please phone 911 or go to the nearest emergency room. For other emergencies a useful resource is the Calgary Distress Centre (24 hours) at **(403) 266-1605**. Non-urgent concerns should be reserved for a scheduled appointment.
- You can also call me at **(403) 255-8577**. Be aware, however, that I am not always available, particularly after hours, and may not be able to return your call immediately.

**Complaints and Questions**

- It is important to me that you feel you are benefiting from our meetings together. If at any time you are unhappy with the service you are receiving or if you are unsure about the goals or purposes of treatment, please express your concerns to me directly. I will do my best to resolve your concerns and answer your questions.
- If you would prefer, I will also assist you with a referral to another therapist.
- If I can improve the service you are receiving in any way, please let me know.

**YOUR SIGNATURE**

I have been informed of the procedures and conditions as outlined in this letter. I have had an opportunity to discuss these procedures and conditions with my therapist and I am satisfied that my questions have been answered to the extent possible. I accept the help offered with full knowledge and understanding of the relevant procedures and conditions.

\_\_\_\_\_  
 Name Signature Date

\_\_\_\_\_  
 Name Signature Date

## Intake Questionnaire – Adult

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

Your Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Never married  Exclusive dating  
*(check all that apply)*  Cohabiting  Married  Remarried  
 Separated  Divorced  Widowed

*(If applicable):* For how long have you *currently* been married, cohabiting, separated, divorced, or widowed? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

How many of your children live with you? \_\_\_\_\_

Education:  Some high school  High school  
*(highest level)*  Technical / Trades  2-year associate degree  
 Some undergraduate college or university  
 Undergraduate degree  Some graduate level  
 Graduate degree: \_\_\_\_\_

Income:  \$0-30,000  \$31-60K  \$61-90K  
*(household annual)*  \$91-120K  \$120-150K  \$150K +

Current Occupation: \_\_\_\_\_

Years at Current Job: \_\_\_\_\_ Hrs per week: \_\_\_\_\_

Do you enjoy your work?  A lot  Moderately  Very little

Career Goals: \_\_\_\_\_

### SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**. The first six symptoms (a-f) relate to your relationship with your spouse or partner. (If you are single, circle "0").

*(Circle a number)*

a. Not talking to each other	0	1	2	3	4
b. Having bad arguments	0	1	2	3	4
c. Lack of trust between us	0	1	2	3	4
d. Feeling lonely in the relationship	0	1	2	3	4
e. Lack of affection and caring between us	0	1	2	3	4
f. Feeling unhappy about our relationship	0	1	2	3	4
g. Feeling sad, down or depressed	0	1	2	3	4
h. Avoiding certain people or places	0	1	2	3	4
i. Loss of interest in activities I normally enjoy	0	1	2	3	4
j. Low energy/feeling tired	0	1	2	3	4
k. Sleep problems (insomnia, not staying asleep, or early waking)	0	1	2	3	4
l. Eating too much or too little	0	1	2	3	4
m. Not able to think clearly	0	1	2	3	4
n. Feeling no pleasure or joy in life	0	1	2	3	4
o. Anxiety attacks	0	1	2	3	4
p. Worrying about things	0	1	2	3	4
q. Angry outbursts	0	1	2	3	4
r. Low self-esteem or low self-confidence	0	1	2	3	4
s. Feeling guilty	0	1	2	3	4
t. Feeling too stressed	0	1	2	3	4
u. Thoughts of suicide	0	1	2	3	4
v. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0	1	2	3	4
w. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0	1	2	3	4
x. Not getting my work done	0	1	2	3	4
y. Feeling unhappy with my workplace	0	1	2	3	4

Symptoms Total: \_\_\_\_\_ / 100

**Medical:** Do you have any medical problems?  Yes  No

If yes, please list them: \_\_\_\_\_

Do you take any prescription **Medications**?  Yes  No

If yes, please list them:

Medication	Dose	Purpose	Since

Do you **Exercise**?  Yes  No If yes, what do you do?

Do you drink **alcohol**?  Yes  No

If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): \_\_\_\_\_

Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): \_\_\_\_\_

Do you **smoke** tobacco?  Yes  No

If yes, please estimate quantity per day: \_\_\_\_\_

Do you drink **coffee/ tea**?  Yes  No

If yes, please estimate quantity per day: \_\_\_\_\_

Do you use any **illicit drugs**?  Yes  No

If yes, please specify: \_\_\_\_\_

If you drink alcohol or use illicit drugs, please answer the following questions:

C. Have you ever thought you should **Cut**  Yes  No **down** on your drinking/ drug use?

A. Have people **Annoyed** you by  Yes  No criticizing your drinking/ drug use?

G. Have you ever felt bad or **Guilty** about  Yes  No your drinking/ drug use?

E. Have you ever had a drink / used drugs  Yes  No in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover?

Are you concerned about the alcohol and/or drug use of anyone close to you?  Yes  No If yes, who?

Are you experiencing **abuse** in any of your **current** relationships?

Yes  No If yes:  Physical  Emotional  Sexual  
By whom? \_\_\_\_\_

Have you ever experienced **abuse** in your **past** relationships?

Yes  No If yes:  Physical  Emotional  Sexual  
By whom? \_\_\_\_\_

**REASONS FOR SEEKING FOR COUNSELING**

Check only those that apply. If you check more than one, please select your top three and rank them from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

- |   |       |
|---|-------|
| (√) (Check all that apply)  | Rank  |
| <input type="checkbox"/> Depressed Mood                               | _____ |
| <input type="checkbox"/> Anxiety                                      | _____ |
| <input type="checkbox"/> Anger Management                             | _____ |
| <input type="checkbox"/> Self-Esteem or Confidence                    | _____ |
| <input type="checkbox"/> Social Difficulties                          | _____ |
| <input type="checkbox"/> Stress Management                            | _____ |
| <input type="checkbox"/> Bereavement/ Loss                            | _____ |
| <input type="checkbox"/> Domestic Violence or Abuse (Current)         | _____ |
| <input type="checkbox"/> Premarital Counselling                       | _____ |
| <input type="checkbox"/> Communication Problems/Relationship Conflict | _____ |
| <input type="checkbox"/> Sexual Intimacy Concerns                     | _____ |
| <input type="checkbox"/> Emotional or Sexual Infidelity/affairs       | _____ |
| <input type="checkbox"/> Other Marital/Relationship Concerns          | _____ |
| <input type="checkbox"/> Separation / Divorce / Relationship Break-Up | _____ |
| <input type="checkbox"/> Custody Concerns                             | _____ |
| <input type="checkbox"/> Parenting                                    | _____ |
| <input type="checkbox"/> Parent-Adult Child Relations                 | _____ |
| <input type="checkbox"/> Blended Family Issues                        | _____ |
| <input type="checkbox"/> Family Conflict                              | _____ |
| <input type="checkbox"/> Work problems                                | _____ |
| <input type="checkbox"/> Education/ Career Concerns                   | _____ |
| <input type="checkbox"/> Financial Concerns                           | _____ |
| <input type="checkbox"/> Legal Concerns                               | _____ |
| <input type="checkbox"/> Medical Issues                               | _____ |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs)              | _____ |
| <input type="checkbox"/> Gambling Difficulties                        | _____ |
| <input type="checkbox"/> Other Addictions (i.e. Sex, Shopping)        | _____ |
| <input type="checkbox"/> Eating Disorder                              | _____ |
| <input type="checkbox"/> Weight Management / Body Image               | _____ |
| <input type="checkbox"/> Spiritual Problems                           | _____ |
| <input type="checkbox"/> Child – Behavioral Problems                  | _____ |
| <input type="checkbox"/> Child – Mood / Anxiety Problems              | _____ |
| <input type="checkbox"/> Child – Academic Problems                    | _____ |
| <input type="checkbox"/> Child – Social/ Relational Problems          | _____ |
| <input type="checkbox"/> Other _____                                  | _____ |

**PREVIOUS TREATMENT**

Have you participated in therapy or counseling in the past?  
 Yes     No    If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there any organizations or agencies that you are currently receiving assistance or support from?  Yes    No   If yes, please specify: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES**

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

- |   |            |
|---|------------|
|   | Who? When? |
| <input type="checkbox"/> Depression   | _____      |
| <input type="checkbox"/> Bipolar Disorder   | _____      |
| <input type="checkbox"/> Schizophrenia  | _____      |
| <input type="checkbox"/> Other psychiatric disorders (i.e. psychosis, hallucinations) | _____      |
| <input type="checkbox"/> Suicide  | _____      |
| <input type="checkbox"/> Physical / Sexual Abuse                                      | _____      |
| <input type="checkbox"/> Substance Abuse (Alcohol/Drugs)                              | _____      |
| <input type="checkbox"/> Autism/Asperger’s Syndrome                                   | _____      |
| <input type="checkbox"/> Eating Disorder  | _____      |
| <input type="checkbox"/> Chronic Illness (please specify illness)                     | _____      |
| <input type="checkbox"/> Accidental or Untimely Death                                 | _____      |
| <input type="checkbox"/> ADHD or Learning Disorders                                   | _____      |
| <input type="checkbox"/> Other  | _____      |

**OTHER INFORMATION**

Please include here any additional background information you feel would be helpful for your therapist to know:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**REFERRAL SOURCE**

Please let us know how you learned about Cobb Counselling & Consulting. (Check all that apply):

- Internet search / website
- Word of mouth (family/friend)
- Another professional (physician, lawyer, etc.)
- Workshop or seminar
- I am a returning client
- My employer or health insurance provider
- Other \_\_\_\_\_

Thank-you very much for taking the time to fill out this questionnaire.