Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Psychotherapy Intake - Adult

Patient Information

Name_____ Date_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Cell Phone_____

Work Phone_____ E-Mail_____

☐ Yes, sign me up for the monthly e-newsletter

Date of Birth *day*_____ *month*_____ *year*_____ Age_____

Occupation_____ Referred By_____

Emergency Contact Information

Name_____ Relation_____

Phone_____ E-Mail_____

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Spouse/Partner and/or Children (if applicable)

Name_____ Relation_____ Age_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

• Current relationship. (please circle)	Married Never married Dating one person	Divorced Living together Not dating anyone at present	Separated Dating more than one person	Widowed
• Are you satisfied with your current relationship situation?				
• Current employment.	Employer	Position	How long have you been employed here?	

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• If you are not employed, what is your main life activity?		
• What is your ultimate job or life fantasy?		
•Have you ever suffered from		
Depression?	How often and for how long did you have these feelings?	
Anxiety or panic?	How often and for how long did you have these feelings?	
Suicidal thoughts?	How often and for how long did you have these feelings?	
• How would you rate your stress level at this time?	1 = no stress 10 = constant stress	Do you know what is causing your stress?

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• Please tell me about the most significant stressful events in your life.	1
	2
	3
	4
	5
• Do any of these events still affect your life today?	
• What (if any) are your religious or spiritual beliefs, or training?	

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• Do you have a support network? - friends, family or acquaintances	
• What are your greatest strengths, talents and resources?	
• What are some of your favourite leisure activities?	

Conditions of Therapy and Confidentiality Agreement

Privacy and Confidentiality

You have the right to the confidentiality of our sessions. With the exception of the situations described below, I will not disclose to anyone what we discuss in our sessions, or even that you are my client, without your written permission.

The following are the exceptions to your right to confidentiality.

1. When I must disclose information to prevent clear and imminent danger to you or another person;
2. When legal requirements demand that I must submit confidential information. In this case, I will make every effort to submit only information that is specifically related to the legal requirements.

In managing and storing your personal information, I will act in accordance with the Canadian Personal Information Protection and Electronic Documents Act.

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Ending Therapy.

You have the right to terminate therapy at any time, and you will normally be the one who decides when therapy will end. However, I reserve the right to terminate therapy in the following situations:

1. If cancellations or no-shows become excessive and cannot be dealt with in the therapeutic relationship. I will discuss this with you, and I may choose to terminate therapy.
2. If I am not, in my judgment, able to help you because of a particular concern you have, or because my training and skills are, in my judgment, inappropriate to assist you. I will discuss this with you, and I may choose to terminate therapy. In this case, if you wish, I will refer you to another therapist who may meet your needs.
3. If you verbally or physically threaten or harass me, or do violence to me, I will terminate therapy immediately.

Emergency Information

If at any time you believe that you cannot keep yourself safe, or you are experiencing a life threatening emergency, please call 911 or go to your nearest emergency room for assistance.

I have read the preceding information and understand my rights and responsibilities as a client.
My signature below acknowledges this understanding and indicates that I accept the conditions of therapy.

Patient Signature_____ Date_____

Therapist Signature_____ Date_____

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Patient/Client Agreement Form

Each patient/client is required to read the following before treatment. Your signature below acknowledges the following:

1. I understand that Naturopathic and other services provided at OIHC are not covered by the provincial government, yet their expenses may be covered by private insurance plans and may be tax deductible.

2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and MasterCard (no other credit card) are acceptable methods of payment

3. Forty-eight hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.

4. Items purchased are non-refundable, whether or not they have been opened.

5. I understand that natural health care is a joint responsibility between me (the patient/client) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.

6. I understand that I may contact my health care provider by phone or e-mail and that all emails will be screened by reception and forwarded to the appropriate Naturopathic doctor/practitioner.

7. I realize that integrative health care/medicine is not an isolated system and that all our health-care providers welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

Patient Signature_____ Date_____