Assigned Counsellor

Rate of pay

Date opened

SHAMROCK wellness services

Client contact information

Client Name & DOB (current age)	
Parent or Guardian name	
Address	
Phone (s) Cell & Home (both client and guardian)	Permission given for messages Y /N
Email (s)	Client Parent or guardian Funder
Intake questions	1. Have you been referred to a specific counsellor (by whom and which counsellor?) _____ 2. Would you prefer a male or female?_____ 3. What are the days and times you are available (pls note that not all times can be accommodated exactly) _____ 4. Would you be ok with a Master level intern?_____ 5. Do you need a reduced fee?_____ 6. Is the client connected to other supports and resources (pls name) _____ _____ _____ _____ 7. Other _____ _____ _____ _____ _____ 8. Name some of the challenges you currently struggle with (eg anxiety, depression, trauma, relationships, addictions) _____

Funding Source	Funding main contact name _____ Email_____ Fee/hr_____ Phone number _____ Claim No. if CVAP: _____
Payment information	Credit Card number_____ Name _____ exp_____ CCV code_____ If paying by Credit Card: M/C / Visa / AM EX Private payments please circle preferred method: Cash Cheque Etransfer Credit card (2.9% + 0.30 $ fee added) • It is Clients responsibility to ensure funding is complete before start of sessions, clients must keep track of sessions remaining and end of funding period • For E-transfer use passcode "shamrock" • Credit Card# must be given before first session and will be charged for missed Intakes

Administration notes:

Date Open file _____

Date Closed file _____

Change of fees and date changed:

1. _____
2. _____
3. _____

Other:

Emergency Medical:

	Name	Relationship	Phone
Emergency Contacts (2)			
Allergies & Medications			
Physicians Name & Phone			

In the event emergency medical aid/ treatment is required due to illness or injury during the process of attending workshops or individual sessions provided by Shamrock Wellness Services, I authorize the counsellors, facilitators, or volunteers to:

1. Secure and retain medical treatment and transportation if needed
2. Release records upon request to the authorized individuals or agency involved in the medical emergency treatment.

The authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed 'life saving' by the physician.

Client signature _____ Date_____

Parent or Guardian signature _____ Date_____