

# Client Intake Form

## bodymindmotion

*sport consultation and psychological services*

April Clay, M.Ed., R. Psych

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[www.bodymindmotion.com](http://www.bodymindmotion.com)

[www.ridingoutofyourmind.com](http://www.ridingoutofyourmind.com)

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of Years Married or partnered: \_\_\_\_\_

Children: \_\_\_\_\_

Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

May I put you on my email newsletter list? Yes \_\_\_ No \_\_\_

*Information will not be sold or distributed to any other person or agency.*

Please indicate which newsletter(s) you would like to receive:

- Riding Out of Your Mind: Equestrian Sport Psychology Tips
- Bodymindmotion: Sport Psychology Tips
- Living Well: Tips for Healthy Living

Sport:

Coach:

Club/team or organization name:

Would you like your coach to be involved?

Yes \_\_\_ No \_\_\_

If yes, in what way? \_\_\_\_\_

Upcoming Competitive Events:

Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any major health concerns:

Are you presently on any medication? Yes\_\_\_ No\_\_\_

If yes, name of medication(s), purpose and amount:

Who referred you to April? \_\_\_\_\_

May I thank this person for their referral? Yes\_\_\_ No\_\_\_

BRIEFLY DESCRIBE YOUR REASON FOR SEEKING HELP AT THIS TIME:

**CONFIDENTIALITY**

Generally, all information that is given to us is kept strictly confidential. However, there are four exceptions to the above statement:

1. If a Release of Information has been signed to a specific person or persons with regard to specific information.
2. If, in the professional opinion of the psychologist, there is a potential for harm to self or others.
3. If there is a legal or statutory obligation to report (as in cases of child abuse).

4. If the psychologist is legally required by a court of law to testify, submit a report or release records.

**CANCELLATION OF APPOINTMENTS: IMPORTANT!**

Please be aware that appointments cancelled **without 24 hours notice** will be billed at the regular rate.

**PAYMENT: The hourly fee of \$150.00 (no GST) is due upon completion of the session. Credit cards are accepted, and an official receipt for insurance or tax purposes will be issued. Thank you.**

I \_\_\_\_\_ understand and accept these terms.  
(Signature)

**CONSENT FOR TREATMENT (where applicable):**

If your child is under the age of 18 years, permission is required from a guardian. If you are currently separated or divorced from the child's other parent, the other parent must be notified and give consent to treatment.

1. I \_\_\_\_\_ consent to \_\_\_\_\_ being seen by April Clay,  
R. Psych. for the purposes of counselling.  
Signature \_\_\_\_\_ Dated: \_\_\_\_\_
  
2. I \_\_\_\_\_ consent to \_\_\_\_\_ being seen by April Clay,  
R. Psych. for the purposes of counselling.  
Signature \_\_\_\_\_ Dated: \_\_\_\_\_