

Client Intake Form

bodymindmotion

sport consultation and psychological services

April Clay, M.Ed., R. Psych

220, 1982 Kensington Road NW

Calgary, Alberta T2N 3R5

403.283.5525

www.bodymindmotion.com

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: _____