shabui studios
EXPRESSIVE ARTS THERAPY CENTRE

Counselling Agreement

1. DOWNLOAD AND COMPLETE, OR COMPLETE AGREEMENT FORM IN PERSON WHEN YOU COME FOR YOUR FIRST SESSION.
2. BOOK YOUR SESSION TIME BY CALLING 604.996.2304, OR REQUEST AN APPOINTMENT VIA EMAIL SUBMISSION.
3. MAKE PAYMENT ARRANGEMENTS IN PERSON (CHEQUE OR EXACT CASH) OR CREDIT CARD VIA PAYPAL AND YOUR EMAIL.

CONTACT INFORMATION

Reservation Date: _____ Date of first session: _____

Name: _____ Age: _____

Address: _____ City: _____

Postal/Zip Code: _____ Province/State: _____

Home Phone: _____ Email: _____

Emergency Contact: _____ Mobile: _____

IMPORTANT INFORMATION

I will notify my Counsellor at least 24 hours in advance if I will be unable to attend a session. This will enable me to reschedule the session for another date.

I UNDERSTAND THAT I WILL BE CHARGED FOR THE SESSION IF I DO NOT NOTIFY MY COUNSELLOR.

I also understand that I must complete my sessions within 2 weeks of the conclusion of my session term (ie. 4 or 8 sessions). Special circumstances may be considered if requests are timely. If a client does not complete contracted sessions, and a refund is permitted for any prepaid sessions, the sessions attended will be charged at the Single Session rate.

Please make checks payable to "BONNIE AYOTTE."

STANDARD SESSION PACKAGES		1 Session	4 Sessions	8 Sessions
INDIVIDUAL	60 min	❒ $110	❒ $396	❒ $775
COUPLES	60 min	❒ $110	❒ $396	❒ $775
FAMILY	90 min	❒ $135	❒ $486	❒ $995
ART SESSION PACKAGES*		**1 Session**	**4 Sessions**	**8 Sessions**
INDIVIDUAL	60 min	❒ $110	❒ $425	❒ $850
COUPLES	60 min	❒ $110	❒ $425	❒ $850
FAMILY	90 min	❒ $145	❒ $525	❒ $1050
OPEN STUDIO SUPPORT				
OPEN THERAPY STUDIO		1 hour	❒ $30	
OPEN THERAPY STUDIO DEBRIEF		30 min	❒ add $55	
ONGOING WORKGROUPS**				
Sexual Abuse/Trauma Recovery		16 weeks	❒ $350	
Addiction & Art		16 weeks	❒ $350	

SESSION FEES
12% HST
TOTAL FEES
PAYMENT METHOD
PAYPAL ❒
CASH ❒
CHEQUE ❒

* Prices include art materials.

** Please call ahead to find out when the next Workgroup is running. We are currently developing new psychoeducational Workgroups. Call for updates.

_____
Counsellor Signature

_____
Client Signature

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Counselling Intake

The following information is helpful in developing your individual treatment plan, and will be kept strictly confidential.

1. MAKE A COUNSELLING RESERVATION.
2. PRINT FORMS OR CALL TO REQUEST THEM BY MAIL.
3. COMPLETE AND SIGN FORMS.
4. BRING FORMS TO YOUR FIRST APPOINTMENT.

IDENTIFYING INFORMATION

Name: _____ Date: _____

Address: _____ City: _____

Prov/State: _____ Postal/Zip: _____

Home Phone: _____ Mobile: _____

Email/Text: _____ Emergency Contact: _____

Gender: _____ Date of Birth: _____/____/_____ Age: _____

Occupation: _____ Employer: _____

Dr. Name: _____ Dr. Phone Number: _____

Do you or your family have Native Status? ❑ me ❑ my partner ❑ my kids

RELATIONSHIP STATUS

STATUS: ❑ Single ❑ Married ❑ Separated Partner's Name: _____

❑ Divorced ❑ Engaged ❑ Common law Partner's Gender: _____

❑ Partners ❑ Widowed Year: _____ Years in Relationship: _____

CHILDREN AND DEPENDENTS

1. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
2. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
3. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
4. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
5. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
6. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
7. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑
8. _____ Age: _____ Relationship: _____ Live with ❑ Dependent ❑

PARENTS AND SIBLINGS

Mother: _____ Age: _____ Father: _____ Age: _____

1: _____ Age: _____ 2: _____ Age: _____

3: _____ Age: _____ 4: _____ Age: _____

5: _____ Age: _____ 6: _____ Age: _____

7: _____ Age: _____ 8: _____ Age: _____

PERSONAL FACTORS

Please rate the quality of your present health: ❑ poor ❑ average ❑ excellent

Do you have a diagnosed medical condition? Explain: _____

Do you take any medications? Explain: _____

Have you ever been diagnosed with a mental illness? Explain: _____

Do you have any addictions? Explain: _____

What type of foods do you often eat? _____

Do you regularly exercise? Explain: _____

What is your highest level of education? _____

Did you have any problems in school? Explain: _____

Have you ever been arrested? Explain: _____

Have you tried counselling before? Explain: _____

Name of Therapist: _____ Dates (From/To): _____

CURRENT CONCERNS

What brings you to counselling at this time? _____

_____

_____

_____

_____

Please rate the severity of your concerns: ❑ mild ❑ moderate ❑ severe

Is there any concern of violence in your life at this time? _____

_____

_____

_____

Please rate the severity of any violence concerns: ❑ mild ❑ moderate ❑ severe

Is there any concern of suicide in your life at this time? _____

_____

_____

_____

Please rate the severity of any suicide concerns: ❑ mild ❑ moderate ❑ severe

Are there people in your life you can call on for support? Please list: _____

_____

_____

If you ever need to talk to someone before your counsellor is available to speak with you, please call the Crisis Line at 604.820.1166. They are available 24 hours per day. If you need more urgent help, please go to an emergency room where you can get help if you feel you may hurt yourself. By signing this document, you agree not to harm yourself or others during the term of your treatment plan.

PLEASE CIRCLE SYMPTOMS THAT HAVE CONTRIBUTED TO YOU COMING IN TODAY

BEHAVIORS:

Over eating	Under eating	Insomnia	Withdrawal
Work too hard	Phobic avoidance	Suicide attempts	Purging
Procrastination	Temper outbursts	Can't keep a job	Smoking
Excessive drinking	Sleep disturbance	Loss of control	Illegal drug use
Risk taking	Nervous ticks	Excessive crying	Aggression
Compulsions	Odd behaviors	Eating problems	Impulsivity

FEELINGS:

Anger	Guilt	Unhappiness	Annoyed
Happiness	Boredom	Sadness	Conflicted
Confusion	Depression	Regret	Loneliness
Anxiety	Hopelessness	Contentment	Fear
Excitement	Helplessness	Optimism	Energetic
Relaxed	Tense	Panic	Jealous
Worthlessness	Distracted	Superior	Hope

PHYSICAL SYMPTOMS:

Headaches	Dry mouth	Twitches	Sexual Disturbances
Bowel issues	Visual disturbance	Stomach complaints	Heart palpitations
Chest pain	Tremors	Hearing things	Numbness
Skin issues	Fatigue	Tension	Excessive sweating
Flushes	Dizziness	Burning/Itching	Back pain
Fainting spells	Tingling	Heart problems	Muscle spasms
Rapid heartbeat	Blackouts/lost time	Watery eyes	Don't like being touched

PRACTICAL ISSUES:

Relational	Family	Housing	Financial
School	Social	Legal	Access to services
Transportation	Language barriers	Communication barriers	Job/Career

IN THE PAST 12 MONTHS I HAVE EXPERIENCED: (Please circle)

Death of spouse	Divorce	Separation	Jail term
Death of close family	Personal injury/illness	Fired from work	Marital reconciliation
Retirement	Health of family member	Pregnancy	Miscarriage/Still birth
Abortion	Addition to family	Change in finances	Death of friend
Foreclosure/Bankruptcy	Child leaving	Trouble with inlaws	Outstanding success
Change in living conditions	Working night shifts	Starting/finishing school	Trouble at work
Change in debt	Emotional/Physical abuse	Traumatic event	Sexual abuse/Assault

PLEASE CIRCLE SYMPTOMS THAT HAVE CONTRIBUTED TO YOU COMING IN TODAY

In order to understand me _____

_____

_____

What really hurts me _____

_____

My childhood was _____

_____

My mother _____

_____

My father _____

_____

God is _____

_____

My greatest hurt was _____

_____

My greatest regret is _____

_____

The best day of my life _____

_____

The worst day of my life _____

_____

What I wish I could change about myself is _____

_____

_____

What holds me back is _____

_____

What has helped me before is _____

_____

_____

My goals and expectations for counselling are _____

_____

_____

_____

_____

_____

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Informed Consent

CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY

I understand that all records and communications relating to the provision of clinical counselling services offered to me are confidential and may not be disclosed without my written consent. I understand that the law places certain limits on the confidential nature of these services and that these limits to confidentiality typically arise, but are not limited to, situations such as the following:

- If I present an imminent danger to self or others
- If there is suspicion of child abuse or a child in need of protection
- If a vulnerable adult is being abused or neglected
- If I intend to have sexual contact or share IV drug needles that could spread HIV and/or AIDS
- If a judge sends a signed, valid court order requesting information regarding my treatment.

I understand that my counsellor may discuss my case with other counsellors or clinical supervisors, without my written consent, for the purposes of peer support and the best therapeutic outcome in my case. Whenever possible, identifying information will not be shared.

COUNSELLING SERVICES

I understand Shabui Studios is a private counselling practice. The type and length of services are generally determined following a comprehensive intake and thorough discussion to determine the best approach to address the concerns I bring with me. I understand and acknowledge that I have a reasonable promise of success in counselling that is consistent with my commitment, effort, and abilities, and that circumstances can be made but guarantee of success cannot.

I understand and acknowledge that there are possible risks with counselling as well as with the choice to do nothing about the reasons for which I am seeking counselling, and that my counsellor might recommend ending services if my goals have been reached, if I am not progressing under my counsellor's care, or if my counsellor is not qualified to provide services in a particular clinical area. Should my counsellor not be qualified in any particular area, I will be provided with referrals for more appropriate services. I understand and acknowledge that, while counselling provides significant benefits, it can cause distress or uncomfortable feelings. I believe the benefits outweigh this risk and choose to participate in counselling services, anyway. My counsellor will help me through the process of change necessary to cope with such challenges while I learn to make healthier choices for my life. With this support, I remain the author of my own unfolding life story.

I understand and acknowledge that my counsellor has the right to terminate treatment in the event that I threaten or become aggressive or violent against my counsellor.

ACKNOWLEDGEMENT AND CONSENT

I have had the opportunity to read this document, and to ask and have answered any questions or concerns I have about this document, or arising from this document. I am able to make an informed decision regarding counselling services, and therefore voluntarily consent to begin and receive counselling services through Shabui Studios. I agree to pay in full for each hour, as agreed in my Counselling Agreement, and to subsidize where necessary any insurance or third party coverage I may have so as to pay the full fee required. I understand I will be charged for any missed appointments, should I fail to provide the necessary notice of cancellation.

Client Signature	Counsellor Signature
Client Signature	Counsellor Signature

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