Oakville MASSAGE & WELLNESS Clinic

AMBER OKE-MAC NEIL, MSW, RSW, CSFT
Psychotherapy and Counselling

INTAKE FORM

OFFICE USE:
File Number: _____ **Date of first contact to OMWC:** _____

Date of First Appointment: _____

File Name: _____ **D.O.B:** _____

_____ **D.O.B:** _____

Children: _____ **D.O.B:** _____

_____ **D.O.B:** _____

_____ **D.O.B:** _____

Address: _____

Telephone: Home: _____ **Work:** _____

Cell: _____ **Other:** _____

Indicate where messages can be left: Home: ☐ **Work:** ☐ **Cell:** ☐ **Other:** ☐

Email address_____

I consent to OMWC Reception contacting me regarding scheduling and appointment reminders: Yes☐ **No**☐

Where did you hear of this service: Through Oakville Massage and Wellness Clinic ☐
Psychology Today Website ☐
Findasocialworker.com Website ☐
NetworkTherapy.com Website ☐
Other (specify) ☐

Insurance Coverage or billing information: Many Insurance Benefit Plans will cover Registered Social Work services at the MSW level. Please advise us of any questions you have.

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RELEVANT HEALTH HISTORY: _____

_____

A) Family doctor: _____

B) Other health practitioners: _____

C) Medications: _____

OTHER RELEVANT CONTACTS: _____

SERVICES TO CHILDREN (Principles surrounding consent to care and disclosure of information for children will be discussed with you)
Please indicate yes/no for any of the following if relevant:
Services to Children: _____ **Age(s) of Child/Children:** _____
Is Family Intact: _____
Have any Legal Custody Orders been established: _____
Is there a court order: _____
Has non-custodial parent been informed of service: _____

What has child been told about the service: _____

_____

_____

PRESENTING CONCERN FOR COUNSELLING:

_____

_____

_____

_____

Therapist Signature: _____

Client signature: _____