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**Therapy, Mediation, Custody Assessments, Parenting Coordination, Mediation/Arbitration**

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**FAMILY CONSULTATION INTAKE QUESTIONNAIRE**

DATE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

1).NAMES \_\_\_\_\_

PARENT : AGE \_\_\_\_\_ D.O.B. \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

TELEPHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_  
CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ FULL TIME \_\_\_ PART TIME \_\_\_\_\_

SINGLE \_\_\_ MARRIED \_\_\_ SEPARATED \_\_\_ DIVORCED \_\_\_ WIDOWED \_\_\_\_\_

MAY I CALL YOU AT: WORK ? \_\_\_ HOME? \_\_\_ LEAVE A MESSAGE

2.)NAME: \_\_\_\_\_

AGE \_\_\_\_\_ D.O.B. \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_  
(H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_  
CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ FULL TIME \_\_\_ PART TIME \_\_\_\_\_

SINGLE \_\_\_ MARRIED \_\_\_ SEPARATED \_\_\_ DIVORCED \_\_\_ WIDOWED \_\_\_\_\_

MAY I CALL YOU AT: WORK ? \_\_\_ HOME? \_\_\_ LEAVE A MESSAGE

CHILDREN? IF SO PLEASE LIST THEIR NAMES AND AGES:

\_\_\_\_\_  
\_\_\_\_\_

ARE YOU INVOLVED IN A CUSTODY/ACCESS DISPUTE OR DISAGREEMENT? \_\_\_\_\_

WHAT ARE YOU HOPING TO SEE CHANGED AS A RESULT OF COUNSELLING?

\_\_\_\_\_

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**CONFIDENTIALITY:** Before your first counseling session, it is important that you have an idea of the guidelines around confidentiality. The personal information that you discuss is held in strict confidentiality, with the following exceptions:

- 1) I am required to report to the appropriate child welfare authority (i.e., Children’s Aid Society, Catholic Children’s Aid Society, Jewish Child & Family Service, or Native Child & Family Services) and/or other relevant authorities if I have a reasonable suspicion that a child(ren) may be in danger of harm and/or abuse.
- 2) I am obliged to notify the proper authorities if she has a “reasonable suspicion” that a client may harm himself or herself or the other parent.
- 3) I am required by law to release records if they are subpoenaed by court order,
- 4) If you are a minor, parental consent is required for a therapist to meet with you. Conditions of confidentiality are negotiated with you and your parent/guardian.
- 5) If you are attending for marital therapy any information provided, at the therapist’s discretion, may be shared with your spouse or partner.
- 6) For Family Therapy, the parents recognize the need for themselves and minor child to enter into a counselling relationship. Each understands that counselling will be most effective if each party feels free to discuss information that they may not otherwise wish to be privy to others, including any or all legal arenas. For this reason they have agreed not to subpoena or otherwise share any information that was obtained through this process without the express written permission of the other parent.
- 7) There may be times when it is important to consult with other professional connected with you and your family, such as a physician or teacher. No such consultation will occur without a specific reason or without your written consent.
- 8) Information may be used for educational, consultative or supervision purposes. This would not involve disclosures of identifying information.
- 9) Please request a copy of Privacy Policy or view it on [www.vanbetlehem.ca](http://www.vanbetlehem.ca), for further information on storage and retrieval of your confidential information.

**FEES:**

- 1) Fees are set at \$\_\_\_\_\_ per hour and are submitted at the start of each therapy session.
- 2) Some clients find it more convenient to work off of a retainer. Should you provide a retainer, a regular statement of account will be issued. You will be refunded any portion of an unused retainer.
- 3) Fees apply to all clinical, therapeutic and administrative services including consultations with other professionals, written reports, telephone consultations and e-mails.
- 4) As record keeping requirements make it necessary to log each e-mail, telephone call and /or message, and make a record of even the briefest telephone call, there will be a minimum charge of five minutes for every phone and e-mail contact, with exceptions made for brief contacts about scheduling only.

Authorization to proceed with any service will be obtained prior to commencing the service.

- 5) I understand that cancellation of an appointment without 48 business hours notice will be charged the regular full session rate. While therapy sessions may be covered by insurance benefits, coverage does not apply when 48 business hours notice is not provided and I agree to be responsible for full payment of the missed session. This policy will be waived in the event of severe weather.

**THE COUNSELLING RELATIONSHIP:** The counseling relationship is centered on the needs of you, the client. You are encouraged to let me know if you have any concerns or dissatisfaction with the process. I will welcome any feedback that you may have.

**I/We have read and understood the above:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_