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 $160.00 (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: