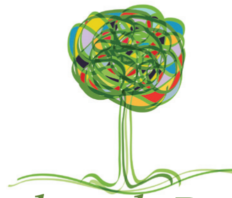
Adolescent & Family Counselling

Individual & Group Therapy

Dialectical Behaviour Therapy

DBT Skills Groups for Adolescents & Parents



Glenbrook Practice
GROWTH THROUGH AWARENESS®

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(Reg No: 2015/308832/07)

CLIENT CONFIDENTIAL INFORMATION

Welcome to Glenbrook Practice. We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information, and wish to leave it out, please feel free to do so.

Your Full Name:..

Address: ....

City: .... Postal code: ....

Home phone: .... Cell Phone: ....

Age: .... Birthdate: .... Birth place: ....

Email address: ....

Education: (Grade completed, and post secondary)..

Current occupation: ....

Person to alert in case of emergency:..

Relationship to you: .... Contact number: ....

Family doctor: .... Contact number: ....

Relationship status: (circle one) Single Married Partnered Seperated Divorced Widowed

Spouse/Partner's 1st name: .... Age:.................Years in relationship:..............................

Children: (gender, age)..

Please describe any significant current or past medical problems: ....

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Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each :

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Have you had previous psychological care or counselling: (circle one) YES NO

If yes, please give the name of the clinician(s) and the months your saw them: (e.g. Nov 06 - Feb 07) :

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Have you ever been hospitalised for psychological difficulty: (circle one) YES NO

If yes, please give the dates and the nature of the difficulty at the time:

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In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much detail as you wish. Use additional paper if you like.

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The agreed contracted fee is R460.00 per 55-minute individual session. Fees cannot be claimed from medical aid, as there is no claim number accredited.

1. The client agrees to take full responsibility for the settling of an account directly after each session. The practice operate on a cash-only basis. Any other payment is by prior arrangement only. Failure to cancel a session without 24 hours notice will result in the full charge being levied for that session.

2. While the practitioner agrees to take measures to ensure the safety and containment of the client, he will not be held liable for any self-inflicted injury and/or relapse by the client or otherwise, either during the course of the session or outside of those times.

3. The practitioner will maintain confidentiality at all times. It is understood that he has permission to liaise with any relevant professionals such as psychologists, psychiatrists and so forth regarding the clients history and process.

4. There are some limits and exceptions to patient confidentiality:

CHILD OR ELDER ABUSE

Generally, Providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or to any local law enforcement agency.

HARM TO SELF OR OTHERS

If a Provider learns that someone is about to kill or do harm to someone else she/he will do her/his best to warn the intended victim. If a Provider learns that a client intends to harm his/her self. The Provider will breach confidentiality to the extent necessary for his/her protection.

You acknowledge that you have read the above information, clarified any uncertainties and that you consider yourself bound to the contents therein.

Client Signature(s)..

Practitioner: J Mitchell ....

Signed at ....

Date:..