TheWellnessCentre

Client Information

Please print clearly

Client Name: _____
Last First MI

Client Date of Birth: _____/_____/_____ Age: _____
DD / MM / YYYY

Parent(s)/Guardian(s) if client is a minor: _____

_____

Physical Address: _____ District: _____

Mailing Address: _____ KY____- _____

For Phone & Email information, please tick box for Preferred Method of Contact

Phone: ☐_____ ☐_____ ☐_____
Home Work Cell

Email 1: ☐_____

Email 2: ☐_____

Current School if client is a minor: _____Grade/Year: _____

Current Employer (Client/Guarantor): _____

Employer Address: _____ Employer Phone: _____

Payment Preference: ☐Self-Pay ☐Insurance ☐Corporate Partner_____ ☐Other_____

Insurance Assignment

Insurance Company: _____
(Please provide copy of both sides of insurance card & fill out and sign Insurance Claim Form in this pack.)

Policy Holder: _____Insurance ID Number: _____

I, _____ (print name) do hereby give full permission and authorize The Wellness Centre to bill my health insurance company for services rendered by The Wellness Centre.

_____ _____/_____/_____
Signature DD / MM / YYYY

INDIVIDUAL ADULT INTAKE FORM

PERSONAL DETAILS

Name: _____ D.O.B.: _____ Age: _____ Gender: _____
Place of Birth: _____ Immigration Status: _____
P.O. Box _____ Postal Code: _____ Street Address: _____
Country of Residence: _____ City or District: _____
Phone: (H):_____ (W):_____ (C):_____
Please give us any special restrictions for leaving a message at the numbers provided:
☐this is a private number and you may leave message freely OR
☐ only leave a name/no. to call back OR ☐ do not leave any messages
Preferred Email: _____

Relationship Status:

- ☐ Single/Never Married
- ☐ Previously Married for: _____ years, name of spouse: _____
- ☐ Separated: Year _____
- ☐ Divorced: Year _____
- ☐ Widowed: Year _____
- ☐ Currently Married for: _____ years, name of spouse: _____
- ☐ In Significant Relationship for: _____ years
- ☐ No. of Biological Children: _____ Names & Ages:_____
- ☐ No. of Other Children: _____ Names & Ages: _____

EMPLOYMENT/EDUCATION DETAILS

Employer: _____ Years of Service: _____
Position Held/Occupation: _____
Education last completed: Primary School / High School/ University/ Vocational School/ Graduate School (please specify type, _____) / Other: _____

Emergency Contact:

Name: _____ Phone: _____
Relationship: _____ Email: _____

REFERRAL INFORMATION:

How did you learn about The Wellness Centre?

- ☐ Self
- ☐ Media(please circle): Yellow pages/TV Show/Radio Show/Newspaper article
- ☐ Friend / Family Member
- ☐ Employer/Co-worker
- ☐ Doctor
- ☐ Lawyer
- ☐ Priest/Pastor
- ☐ Other Counsellor
- ☐ Other, _____

Please explain;_____

Have you had any previous mental health counselling or treatment, if so please mark below? If necessary, separate consent will be obtained for permission for us to contact and correspond with treatment providers *(Please circle all that apply)*:

- ☐ N / A
- ☐ Individual counselling / Pastoral Counselling / Group counselling / Marital or Couples Counselling / Family counselling / Psychiatric Hospitalisation, Treatment or Medication / Other: _____

Please explain when, with whom, and for what reason(s) you were in treatment:

_____

_____

PRESENTING CONCERN:

What has brought you to seek counselling services at this time? What are the most significant stressors/challenges in your life at this time?

_____

_____

_____

_____

HISTORY

Have you experienced any of the following (Please circle all that apply):
Physical abuse/emotional abuse/sexual abuse (under 18)/sexual assault (over 18)/suicide attempt/mental health illness/alcoholism/drug use. Explain: _____

_____

_____

Has anyone is your family had a history of (Please circle all that apply):
Physical abuse/emotional abuse/sexual abuse (under 18)/sexual assault (over 18)/suicide attempt/suicide completion/mental health illness/alcoholism/drug use. Explain:

_____

_____

Describe any significant recent life events, changes, emergencies, or crises, either positive or negative? _____
_____

Are you currently involved in any matters of the Court? If so, please indicate them here:_____

MEDICAL INFORMATION

Name of Primary Physician: _____
Approximate date of last physical exam: _____
Any major health concerns or medication(s) (please indicate dosage): _____
_____
Any recent medical illnesses/emergencies/hospitalizations/accidents:
_____ _____
_____
Any chronic health illnesses/disabilities:
_____
_____
List allergies: _____

Please list all medication/remedies you are taking at present (Name/Dose/am / pm):
1._____2._____
3._____4._____

OTHER PROFESSIONALS INVOLVED
Please provide information regarding any other professionals who may be involved in assisting with your current situation.

- ☐ Family Doctor:_____
- ☐ Psychiatrist:_____
- ☐ Priest or other religious figure: _____
- ☐ Other Mental Health Professional:_____
- ☐ Other Professional:_____
- ☐ N /A

What do you hope will change by coming to counselling? Or, how could you be healthier, happier, or more successful?
_____
_____

Describe any self-improvement you have already achieved and any attempts you have made to overcome these difficulties thus far: _____
_____

How do you cope with stress generally (circle all that apply)?

Praying /Attending church / Avoiding the problem / Exercising / Eating / Shopping
Having sex with significant other / Having casual sex / Bottling up feelings
Isolating yourself / Spending time with friends / Smoking Cigarettes / Drinking Alcohol
Recreational Drugs / Self-harm / Sleeping / Music / Art / Leisure / Meditating / Reading
Watching TV / Other: _____
_____

Thank you for taking the time to complete this form to the best of your ability! Your openness is appreciated and will assist your treatment provider in developing a treatment plan best suited to your needs.

ADULT INFORMED CONSENT

Please read the following sections carefully, as they explain important polices related to payment, confidentiality, cancellation of appointments and complaints. Your signature at the end will tell us you have reviewed the policies and understand them.

All of our mental health professionals are registered, certified, or licensed as required by law and are held to the highest of legal and ethical standards. We are committed to your rights of information regarding office policy, non-discrimination, confidentiality, consent, and competent service. If you have any questions or concerns, please do not hesitate to tell us. For further information visit our website http://www.wellnesscentre.ky, call us at 949.9355, fax 949.9433, or email info@wellnesscentre.ky. In case of a mental health emergency call 911 or proceed to the GT Hospital for urgent care.

CORPORATE PARTNERS

All employees of our Corporate Partners receive individual, family, and couples counselling at no cost to them. Family members of employees may also receive free services or a 20% Corporate Partner discount depending on the company. Corporate Partner employees also receive a discount for specialised services. Our 2016 Corporate Partners are: **Appleby Cayman Ltd., Appleby Trust, Butterfield Bank, KPMG, Water Authority Cayman, & Walkers Global**. Please identify yourself as an employee of one of these companies at the time of booking.

COMPLAINTS

If at any time you believe your rights have been violated or you have concerns about the quality of service received you are encouraged to speak to your therapist. If you are not able to resolve your concerns, you may contact the Director, Shannon Seymour, in writing. *Client Satisfaction Surveys* are also available at your request. If no course of action has been helpful to you, you also have the right to speak to a member of the Health Practice Commission at 949.2813 or http://www.dhrs.ky/hpc/contact.php. The Cayman Islands Council for Professionals Allied with Medicine has set out a code of practice and guidelines for the provision of counselling services for your protection.

CONFIDENTIALITY

Unless you grant us permission to do so in writing, we will not inform anyone that you are receiving therapy, nor will we disclose the content of your treatment. Additional consent will be required for The Wellness Centre to provide treatment to minors and to exchange information to a third party. Family matters will also require consent from all primary adults involved before treatment materials will be released. You may revoke your permissions in writing at any time. Please note that client records will remain property of The Wellness Centre for a period of 10 years, after which time they will be destroyed. We function as a clinical team at the Wellness Centre and therefore utilise internal peer supervision and consultation regularly as well as professional external consultation and supervision as needed. Any para-professionals, administrators, or interns are also bound by our strict ethical code of confidentiality; they are bound by a written declaration of fidelity to confidentiality. There are few

circumstances when we have a legal obligation to disclose information without your written permission:

- ***Harm to a Child/Elderly Person/the Disabled***: In the event that we are made aware that a vulnerable person is in direct danger, we are legally obligated to make our concerns known to the appropriate authorities.
- ***Harm to Self or Others***: If at any time it is our clinical assessment that your actions or intentions are of a threatening nature to yourself or others we have a legal obligation to make these concerns known to the appropriate authorities.
- ***Order of the Court***. The Court of the Cayman Islands may at any time request information regarding your treatment where it is applicable to current or pending criminal case proceedings.
- ***Professional Supervision***. The Wellness Centre operates as a team structure and performs professional best practices such as clinical meetings, supervision, and consultations in order to ensure the most beneficial care in collaboration with internal practitioners. No outside professionals will be involved. Any conflicts of interest will be identified and may be avoided upon request.

By signing below you indicate that you are fully informed and agree to the preceding information and consent to treatment. By signing below, you also agree that if you or someone in therapy with you makes an allegation against this agency, or any employee acting in the capacity of the agency for a legal or ethical violation we have the right to release information sufficient to our own defense against the charges made.

_____	_____	_____
Signature of Client	Print Name	Date DD/MM/YY
_____	_____	_____
Signature of Client	Print Name	Date DD/MM/YY
_____	_____	_____
Signature of Witness	Print Name	Date DD/MM/YY