north simcoe
family health team

Consent to Treatment

Mental Health Program Objectives:

- Mental health clinicians work to meet client mental health needs, when the need arises
- An appointment with a Mental Health Clinician may provide an access point to mental health support which may include referrals within or outside of the Family Health Team
- The goal of a mental health appointment is for the individual(s) to leave the appointment with a starting plan

Risks and benefits to participating in a mental health program:

- The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of your life.
- Therapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and reduced feelings of distress. However, there are no guarantees of what you will experience.

Confidentiality Agreement:

- I understand that the NSFHT use the Electronic Medical Record to chart notes; which means that your doctor or other primary health care provider will have access to your file when required. Please consult our website for further details.
- I understand that my information is kept confidential unless:

1. There are reasonable grounds to believe that you are likely to harm yourself or another person.
2. There are reasonable grounds to believe that a child under the age of 19 years is at risk of being abused or neglected.
3. Your counselling record has been subpoenaed by a court of law.
4. You disclose that you have been sexually abused by a regulated health professional.

- I understand that the North Simcoe Family Health Team does not provide opinions or recommendations for the purpose of court matters

Name: _____ Signature: _____

Date: _____

Witness: _____ Signature: _____

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Single Session Counselling Clinic

Legal last name: _____ Legal first name: _____

Name used: _____

Pronouns used: ☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Other: _____

Phone number: (___) _____ -_____
☐ Cell ☐ Home ☐ Work

Date of Birth: _____ Age: _____
(Month, Day, Year)

Work/school/other: _____

Family Doctor/Nurse Practitioner: _____

Do you identify as Indigenous (First Nation, Metis, Non-Status, Inuit, other)? Yes ☐ No ☐

Do you have extended insurance benefits (e.g.: EAP, ODSP, school, etc.)? Yes ☐ No ☐

Who lives in your home? Please provide name, age and relationship to you.

Name:	Age:	Relationship to you:
1)		
2)		
3)		
4)		
5)		
6)		

In order to get the most out of your session please complete the following as best you can.

In this session, you will focus on <u>one</u> concern.

1) What is the <u>most important concern</u> that you would like to talk about today?

2) What would be important for us to know about this concern?

Complete other side

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3) What is your hope for our session today?

4) How worried are you about this concern today?

Not really concerned 1 2 3 4 5 6 7 8 9 10 Very concerned

5) How confident do you feel in dealing with this concern?

Not really confident 1 2 3 4 5 6 7 8 9 10 Very confident

6) Are you, a child in your care, or anyone else, at risk of hurting yourself or others?
Yes ☐ No ☐ If yes, please provide details.

7) Think of a time you handled a problem well. What did you do?

8) What would you or someone else say are your strengths?

9) Is there anything else you would like to share? (For example, your. culture, ethnicity, gender identity/expression, language, mental or physical health, religion, sexual orientation.

10) Are you involved in any other services related to your concern today? ☐ Yes ☐ No
If yes, what other services are you connected with?

11) Have you had previous counselling before? ☐ Yes ☐ No
If yes, what was the most/least useful about it?

PHQ-9 & GAD-7

PATIENT NAME: _____ DATE: _____

PHQ-9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score:			

Q6 CORE10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			