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: _____

north simcoe
family health team

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

north simcoe
family health team

Single Session Counselling Clinic

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?

Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

Name:_____ Age: _____ Sex: Male ☐ Female ☐ Date:_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the PAST 7 DAYS, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
2.	felt anxious, worried, or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
6.	avoided, or did not approach or enter, situations about which I worry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
7.	left situations early or participated only minimally due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
9.	sought reassurance from others due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ Age:_____ Sex: Male ☐ Female ☐ Date:_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes