Cortney Pasternak, M.Ed, MA, RP, OACCPP, Therapeutic Counselling Services
ontariotherapist.ca cortney@ontariotherapist.com

First Session Orientation

Thank you for choosing to work with me. I hope I can earn your trust and I look forward to walking alongside you on this journey.

Please print and complete the required paperwork prior to your first session. Completing this paperwork allows us to spend more time on clinical, rather than administrative, issues during the first session. If that is not possible, I ask that you arrive at least 15 minutes ahead of your first scheduled appointment so that you can read and complete these forms.

1. Welcome to Psychotherapy
2. Intake - Individual ***or*** the Intake - Partner
3. Email & Text Messaging Correspondence
4. Informed Consent
5. Financial Agreement & Disclosure
6. Agreement for Supervision (optional – Registered Psychologist benefits)

Some things to know and think about *prior* to our first session:

1. I will collect the paperwork, clarify the importance of confidentiality, answer all your questions, and address any concerns you might have about the paperwork or psychotherapy in general.

2. I prefer to have the name and contact information for your family doctor, previous psychotherapist, and specialists you are currently working with, however I will *not* contact them without prior written consent.

3. It is helpful for me to know about particular symptoms related to your reasons for seeking therapy. It can help us narrow our work and help me understand some of the issues we might focus on.

4. It is particularly helpful for the therapeutic process if you bring a list of goals for your time in psychotherapy. Please be specific if at all possible. This will help me better understand what ways counselling might be helpful and how your life might be different with counselling.

Cortney Pasternak Counselling
cortney@ontariotherapist.com

Name:

Please place a checkmark in the boxes that correspond to current problems you are having:

Feeling sad [ ]
Loss of pleasure [ ]
Loss of interest in activities [ ]
Anxiety or excessive worry [ ]
Difficulty controlling worry [ ]
Difficulty concentrating [ ]
Problems with memory [ ]
Fatigue or loss of energy [ ]
Problems sleeping [ ]
Frequent irritability [ ]
Racing thoughts [ ]
Risky behaviors [ ]
Distractibility [ ]
Decreased need for sleep [ ]
Excessive spending [ ]
Frequent angry outbursts [ ]
Talking excessively [ ]
Feeling restless or “hyper” [ ]
Problems with appetite [ ]
Negative feelings about yourself [ ]
Feelings of guilt [ ]
Feelings of hopelessness [ ]
Tension or muscle tightness [ ]
Feeling bored [ ]
Feeling “different” from others [ ]
Lack of control over life [ ]
Problems with relationships [ ]
Lack of self-esteem [ ]
Problems with sex / sexuality [ ]
Body Image [ ]
Pessimism [ ]
Thoughts of harming others [ ]
Drug or alcohol problems [ ]
Thoughts of suicide or self-harm [ ]
Shyness [ ]
Confusion about career choice [ ]
Lack of direction in life [ ]
Need for more fulfilling life [ ]
Feeling stagnant [ ]
Feelings of helplessness [ ]
Social anxiety [ ]
Problems with trust [ ]
Problems with identity [ ]

Of all the problems you checked, please **underline** the three that are the most troublesome at this time. What do you hope to gain by coming to therapy?

____

____

Name:____

Address:____

Phone Number: Cel:_________________________ Home: __________________________________

Email address: ____

Can I contact you at this number? Y ___ N ___ Can I contact you at this Email: Y _____ N ______

Can I leave messages at this number? Y ____ N ____

Can I leave messages with third parties at this number? Y____ N____

Can I text at this number: Y ______ N _____

Do you regularly check messages? Email: Y: ___ N: ____ Phone: Y: _____ N: _____

For whom is the counselling service: ____

Age:__________

DOB: ____________________

Do you have children?: Y ______ N ________ If so, how many and what are their ages?
____

Emergency Contact:____
Relationship to you: ____

What is/are the main issues bringing you to counselling?
____
____
____
____
____
____
____

What are your main goals for counselling? ____
____
____

Are you on any medications we should be aware of? ____
Do you have any serious allergies I should be aware of? ____________________________________
How did you find out about my services?
Google Search _____________________________________ / Psychology Today ________________
Referral (Name) ____

GOALS FOR THERAPY: (List all and use back if required)

1.

2.

3.

Do you have any other significant medical problems that I should be aware of?

Is there a history of substance abuse that might be helpful to know?

Are you taking any medications?

How were you referred to our office?

How did you find out about my counselling services?

Please indicate any previous counselling experience?
____
____