Psychotherapy Program

Individual Counselling
The Psychotherapy Program offers individual sessions of brief psychotherapy to patients of the Chatham-Kent Family Health Team who are 16 years and over. Skilled psychotherapists will meet with patients who would like to obtain a positive mental health outlook. Patients are required to attend all necessary sessions which occur over a two month period. Two no-show appointments or late cancellations will require a re-referral. Not giving 24 hr. notice is considered a no-show. Sessions will focus on topics such as:

- Depression
- Anxiety
- Stress Management
- Work related issues
- Self-Esteem Enhancement
- Grief, Loss, Adjustment

If you are interested in individual psychotherapy, please: 1) Review the attached Intake Package information. 2) Call the Intake Coordinator directly to initiate your referral. At this time, you will discuss in further detail the essential Intake Package information over the phone with our Intake Coordinator. DO NOT submit forms to your physician's office.

Intake Coordinator: 519-354-2172 extension: 1290

PLEASE NOTE: The Psychotherapy Program does not provide crisis, urgent, or long-term therapy at this time. If you are seeking or require counselling for any of the concerns listed below, please consult your primary care provider who can provide community resources that can better assist you with your needs.

Substance Abuse/Addiction	Domestic Violence
Family/Couples Therapy	Trauma or PTSD
Sexual Assault/Sexual Abuse	Sexual Offences
Criminal Involvement	Anger Management

*** If you require immediate assistance, please attend your nearest emergency department or phone the Chatham-Kent Mental Health Crisis Line: 519-436-6100 or 1-866-299-7447 (telephone and mobile assistance is available 24 hours a day, 7 days a week).

Group Counselling
Cognitive Behavioral Therapy classes are also offered to patients who belong to the Chatham-Kent Family Health Team. Groups are led by skilled psychotherapists and meet patients for two hours a week for eight weeks. This is an educational class that focuses on teaching individual goal setting, understanding thoughts and emotions, stress management, coping with anxiety and worry, and creating a balanced life. For more information please contact: **519-354-2172 extension: 1290.**

Information cannot be released without your written consent. Exceptions do exist; these will be discussed with you.
PLEASE NOTE: Psychotherapy documents become part of your medical records.

Thank you for your interest in the Psychotherapy Program with the Chatham-Kent Family Health Team.

ATTENTION PATIENTS:
DO NOT submit the following forms to your physician's office.
Please call to initiate a referral:
519-354-2172 x1290

CHATHAM-KENT FAMILY HEALTH TEAM

Psychotherapy Program: Intake Package

PERSONAL INFORMATION

Name: _____ Date: _____
Address: _____
Date of birth (dd/mm/yyyy): _____ Age: _____ Gender: _____
Preferred contact number (s): _____ Can a detailed voicemail message be left? _____
Is English your first language? _____ If not, what is your first language? _____
Family Physician: _____ Referring Practitioner (i.e. dietitian, nurse practitioner, etc.): _____

THERAPY

Are you committed to attending individual therapy? _____
Do you have a preference for a specific psychotherapist or prefer a male or female psychotherapist? _____
Have you received therapy with the Family Health Team in the past? If so, with whom? _____
Have you received therapy/counselling outside of the Family Health Team? _____
Please provide previous therapist/counsellor/agency and approximate dates: _____

MENTAL HEALTH

Have you ever had a diagnosis or received treatment for a mental illness? ____ Diagnosis: _____
Have you ever been hospitalized for a mental illness? ____ If so, when: _____
Is there a family history of mental illness or substance abuse? _____
Has a family member been hospitalized for mental illness? _____
Do you, or does anyone close to you have concerns with your anger or aggressive behaviour? _____
Has anyone close to you died by suicide? If so, what was their relation to you? _____
Have you experienced thoughts of suicide, self-harm, or harm to others? ____ If so, how recent/often? _____
_____

CURRENT SYMPTOMS (Please check all that apply)

__ Anxiety	__Changes in appetite	__ Second-guessing	__ Crying spells
__ Depression	__ Excessive energy	__ Fatigue or loss of energy	__ Guilt
__ Grief	__ Low mood	__ Irritability	__ Risky activity
__ Loss of interest	__ Panic attacks	__ Racing thoughts	__ Easily angered
__ Changes in sleep	__ Insomnia	__ Lack of motivation	__ Memory impairment
__ Suicidal ideation	__ Excessive worry	__ Low self-esteem	__ Trouble controlling emotions

PHYSICAL HEALTH

Do you currently engage in physical activity? _____ If so, on average, how often do you exercise? _____
Forms of exercise: _____
On average, how many hours of sleep are you getting a night? _____
Do you have any difficulty falling, staying, or getting back to sleep? _____
Do you have any difficulty eating or have you noticed changes in your appetite? _____
Are you concerned with your alcohol or substance use? _____
Is anyone close to you concerned with your alcohol or substance use? _____

FAMILY HISTORY

Were you adopted? ___ If so, at what age? ___ Have you been in contact with your biological parents? _____
Are your parents still together? ___ If not, how old were you when they separated? _____
Did either parent remarry? ___ If so, how old were you at the time? _____
Who primarily raised you? _____
Do you have a relationship with your mother? ____ Is it healthy? _____
Do you have a relationship with your father? ____ Is it healthy? _____

EARLY DEVELOPMENT

How would you describe your childhood? _____
Did you experience neglect, trauma, and/or abuse growing up? _____
Any major illness in your childhood? _____

PRESENT SITUATION

Are you in an intimate partner relationship? ____ If yes, for how long? ____ Is this relationship healthy? ____
Are you legally married? _____ If yes, for how long? ____ Any prior marriages? ___ If yes, how many? ____
Are you separated or divorced? _____ If yes, for how long? _____
Do you have any children: ____ Names/Ages: _____
Do you have custody/access of your children? _____ Is your relationship with your children healthy? _____
Who do you currently live with? _____
Are you employed? _____ If yes, is your job a source of stress? _____
Are you in school? _____ If yes, is school a source of stress (academically/socially) _____
What hobbies or interests do you have? _____
Are you having difficulty coping with the loss of a friend or family member? _____
Are you a member of a religious or spiritual group? _____

COUNSELLING OBJECTIVES

Please specify what you would like to address, tackle, or focus on in therapy: _____
_____

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