VHMEC
VISIONARY HEALTH MEDICAL EDUCATIONAL CLINIC
"HEALING WITH HEART"

Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1   647-478-9029   FAX: 647-557-3323
vhmec108@gmail.com   info@vhmec.com   www.vhmec.com

Counselling/ Coaching Intake Form

First Name: ________________________________   Last Name: ____

Date of Birth (MM/DD/YYYY): ______________________   Address: ____

City:_____________ Postal Code:______________ Phone: ______________________ Cell: ___________________

Emergency Contact. ____

Email: ____
Family Doctor (Name and Contact):____

List all current medications: ____

List use of other professional services (i.e. naturopathic/homeopathic remedies/vitamins):
____

Reason for Seeking Treatment:
Please describe the problems you are experiencing (what has happened to cause you to seek help at this moment, how do you handle stressors/cope with problems etc):
____

Do you currently have thoughts/ urges/ considerations of harming/ hurting/ killing yourself? □ Yes □ No
Or someone else? □ Yes □ No If yes, whom, please explain?____
Have you in the past? □ Yes □ No If Yes, how long ago? ____
Do you currently have thoughts of wishing you were dead? Yes No
Have you ever had previous therapy/counseling of any kind? Yes No If yes, when, with whom, and for how long?
____
Have you ever been hospitalized for emotional problems? Yes No Or for substance abuse problems? Yes No
If yes to either of the above, please note when, where, and for how long were you hospitalized?
____

Please check all of the items below that describe your situation:
Abuse/trauma – physical, sexual, emotional, neglect
□ Aggression, violence, threats
□ Alcohol use
□ Anger, hostility, arguing, irritability
□ Anxiety, nervousness
□ Attention, concentration, distractibility
□ Career concerns, goals, and choices
□ Childhood issues
□ Codependence
□ Confusion
□ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
□ Decision-making, indecision, mixed feelings, putting off decisions
□ Delusions (false ideas)
□ Dependence
□ Depression, low mood, sadness, crying
□ Divorce, separation, marital conflict, infidelity/affairs
□ Drug use – prescription medications, over-the-counter medications, street drugs
□ Eating problems – overeating, under-eating, appetite, vomiting
□ Emptiness
□ Failure
□ Fatigue, tiredness, low energy
□ Fears, phobias
□ Financial or money troubles, debt, impulsive spending, low income

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□ Gambling
□ Grieving, mourning, deaths, losses, divorce
□ Guilt
□ Headaches, other kinds of pains
□ Health, illness, medical concerns, physical problems
□ Inferiority feelings
□ Impulsiveness, loss of control, outbursts
□ Irresponsibility
□ Judgment problems, risk taking
□ Legal matters, charges, suits
□ Loneliness
□ Memory problems
□ Mood swings
□ Oversensitivity to rejection
□ Panic or anxiety attacks
□ Perfectionism
□ Pessimism
□ Procrastination, lack of motivation
□ Relationships problems (with friends, with relatives, or at work)
□ School problems
□ Self-centeredness
□ Self-esteem
□ Self-neglect, poor self-care
□ Sexual issues, dysfunctions, conflicts, identity issues
□ Sleep problems (too much, too little, insomnia, nightmares)
□ Spiritual, religious, moral, ethical issues
□ Stress and tension
□ Suspiciousness
□ Suicidal thoughts
□ Temper problems, self-control, low frustration tolerance
□ Thought disorganization and confusion
□ Weight and diet issues
□ Withdrawal, isolation
Work problems, employment issues

Substance Use History:

Have you ever experienced a problem with alcohol, drugs, or prescription medications? Yes No If yes, please explain:
____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? □ Yes □ No If yes, please explain:
____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs?
Yes No If, Yes, please explain: ____

Have you had any problems related to use of alcohol/drugs in the past year? □ Yes □ No
If, yes, please explain:
____

Early Personal History:

Birth: ____________________ Childhood Traumas/(Any) Behaviour issues:______________________

Memories that standout:_________________________________

Family Circumstances (growing up years):

Check the statement(s) below that describe the type of family you grew up in: overly close family no "breathing room" everyone was in everyone else's business no privacy boundaries not respected comfortably close family loving shared

many positive experiences supportive distant, everyone did their own thing not much time spent together not a lot of support angry, lots of fighting/hostility verbal abuse and conflicts violence frightening scared to make mistakes

Have any biological relatives ever had any emotional problems or substance abuse? Yes No If yes, please explain:
____

Has anyone in your family ever attempted or committed suicide? □ Yes □ No If yes, please explain:

____

Medical History:
Please list significant medical problems/conditions, and indicate if you are receiving treatment for them:
____
____
Do any of these problems affect your everyday life? Yes No If Yes, how so?
____
Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.):

____

Have you ever blacked out/lost consciousness and/or experienced any type of serious head injury or trauma?
Yes No If so, please indicate when and what happened.
____
List all medications that you currently use:
____
How often do you use the following?
Alcohol: _______/day_______/week_______/month Recreational drugs: ________________________________

Caffeine: ______/day_______/week________/month Sugars: _________/day_________/week_________/month

Education History:
List any and all educational experiences from past to present and highest level of completion:
____

Employment History:
List any and all occupational experiences from past to present
Past:____

Present:____

Relationship History (please circle):
Single: Yes No Details: ____
Married: Yes No Details: ____
Divorced: Yes No Details: ____
Children: Yes No How many? __________________ Gender/Age(s)______________________
Comments regarding stresses in current or previous marriage(s)/relationship(s):
____
____
If you have had problems in the past, what do you think caused those relationships to end?
____
____
Have you ever been abused mentally or physically by a romantic partner? Yes No
Does this apply to your current relationship? Yes No
Do you feel safe? Yes No

Leisure Activities: ____

Spiritual Practice: ____

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INFORMED CONSENT – Counselling & Coaching

TO THE CLIENT: You have the right, as a client, to be informed about therapy treatments of Counselling & Coaching, so as make an informed decision whether or not to undergo the recommended treatment modalities after knowing the benefits and or risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to counselling. I have agreed to the terms outlined:
If you refuse any future therapy this will not affect your receiving other care or future treatments in the Clinic.

- I voluntarily accept Alda Henriques (Coach, Talk Therapy, Neurofeedback, Access Bars & Body Processes Practitioner), Trudy Winders (Counsellor,Grief, Group, Couples Therapist) and Marina Kresovic (Access Bars, Body Processes, Reiki Practitioner) to provide services: Counselling and Coaching in my best interest, to better my health condition.
- I understand that anything I discuss in the above services with Alda Henriques, Trudy Winders, Marina Kresovic is strictly confidential.
- I also understand that I must give express written or verbal permission to Alda Henriques, Trudy Winders, Marina Kresovic to share any aspect of our work together that would identify me specifically and breach confidentiality.
- The only exceptions to confidentiality are in such cases where the issue of potential harm to myself and/or others is disclosed. I acknowledge that in such cases my own safety and/or the safety of others takes priority if the appropriate authorities need to be notified without my consent.
- By signing below I acknowledge that the limits of confidentiality have been explained in full to me, that any questions I have pertaining to the limits of confidentiality have been addressed, and that I am free at any time to request further clarification.
- I understand that there may be some health benefits and risks with Counselling and Coaching.
- I understand that I have the right and the opportunity to ask questions about my condition, discuss further therapy sessions, or any other therapy modalities at any given time.
- I may request additional information regarding the above services.
- I may cancel the appointment up to 24 hours prior to a scheduled session. A missed appointment will mean a missed session and it will not be refunded. (A business day is defined at Monday to Friday, excluding Holidays).
- I understand that all the plans/programs purchased are non-refundable and that the payment must be made before the first session of any of the plans purchased.
- I agree to allow my contact information be exchanged with the other medical professionals within Visionary Health or Team of Care under the guidelines/ jurisprudence of the institute in relation to the above services.
- Payment of services will be expected, based on the fee schedule.
- If any additional telephone, electronic, email or online services apply, I will be informed, and fees could be incurred.
- I further understand that any insurance reimbursement will be my responsibility until I authorize for direct billing to my insurance provider.
- Appointments will ordinarily be 60-90 minutes in duration, unless we agree to additional time and charges.
- In an emergency situation, I understand that I should not solely rely on reaching the practitioner and if there are any indications of an emergency, I am to go to my local hospital, contact the police department or dial 911.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I give consent and authorize Visionary Health Medical Educational Clinic practitioner to contact me in the near future for continued treatment.
- I authorize Visionary Health Medical Educational Clinic to make contact to inform me of educational events, promotions, incentives, newsletters, and of any health benefits.
- I certify that I have read this form or have had it read to me, and that I understand its contents and meaning. I have sufficient information to give this informed consent.
- If the client is a minor under 18 years of age, I the undersigned, take full responsibility and acknowledge agreement to the above statements and act on their behalf.
- I am consenting to a virtual session or an in person clinic and agree to above.

Patient Name: ______________________ Patient Signature: ______________________ Date: ______________________