



Dr. Ross Plews
 DMin M.A. CPC CGT
 Certified Professional Counsellor (#20140046)
 Certified Gottman Therapist (#214)
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Congratulations on your decision to seek out professional counselling. You have probably attempted to resolve your problem(s) by learned methods of coping, but for whatever reason, you are now feeling that you need special help. Please carefully read the following information so that you can benefit the most from your counselling experience.

As a professional counsellor, I will be supportive of you and will create an atmosphere in which you can deal effectively with your struggles. Through the counselling process, you will be presented with opportunities to better understand yourself and therefore be able to express your feelings more freely. You will also learn new strategies for dealing with your problems. This may include removing the problem, changing the way in which you view the problem, coping with the problem, listening to direct advice in dealing with the problem, or being referred to someone else who may be better suited to help you.

As the counselling relationship unfolds, and you gain deeper insight into your problem(s), you may be challenged to recognize contradictions in your thinking. It may be a difficulty that you have not seen or a belief that is harmful to you. It is very important that you allow this process to take place without being offended or discouraged. Often, as a result of these clinical insights, major breakthroughs take place. I look forward to the opportunity of working together with you and trust your experience will be life changing.

Dr. Ross Plews

Professional Accountability

Dr. Plews is a Certified Professional Counsellor, a Certified Gottman Therapist and is a member in good standing with the Professional Association of Christian Counsellors and Psychotherapists. He adheres to their code of ethics. www.paccp.ca

Appointments

We do not provide counselling via text or email. Counselling is provided by appointment only.

Confidentiality

Anything you say in the counselling session will be kept confidential. Your counselor may consult with other counselling professionals, but no identifying information will be disclosed without your written consent. However, please understand that there may be situations where the counselor would have to break confidentiality and report matters to the appropriate authorities.

- If there is an assessment of suicide risk.
- If abuse or neglect whether done in the past or the present, of a child, an elderly person, or a mentally challenged person is reported.
- If there is probability of danger or harm to self and/or others.
- If a court subpoenas case records.

Your counseling records (files) are kept confidential and are the property of CrisisCare Counseling and as such, are deemed records of confidential sessions between counselor and client. Other than as required by law, these records will not be released.



Cash / Debit / Credit Card \$135.00 (plus G.S.T.)

All fees must be paid at the end of each counselling session unless you are covered by your Employee and Family Assistance Plan or Insurance.

Cancellation

It is expected that you will attend counselling sessions on time as scheduled and that in the event you are unable to attend a counselling session, you agree to provide at least 24 hours advance notice. In the event you do not provide 24 hours notice, you may be required to pay a \$50.00 cancellation fee. Requests for letters of attendance or reports will require an additional fee of \$25.00.

Alcohol and Drug Usage

Absolutely no use of alcohol or drugs is allowed prior to a counseling session. Your counselor has the right to terminate a counselling session should you arrive under the influence of alcohol or illicit drugs.

Your participation in counseling is voluntary and you may leave the counselling process at anytime either at your own initiative or in consultation with your counselor.

By signing this document, you are choosing willfully to begin a formal counseling relationship with Dr. Ross Plews. You are agreeing to release, remise and forever discharge and covenant not to sue or hold legally liable CrisisCare Counseling, the counselors, and the supervisors, if applicable, from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process.

I agree that I have had the opportunity to ask for clarification about any of the points listed above, and agree to these parameters.

Name: _____

Signed: _____ / /
 Month Day Year

Name: _____

Signed: _____ / /
 Month Day Year





Confidential Client Information Form (Adult)

The information requested on this form is important for our records and will be held in strict confidence. Information will not be released without your specific request. This form is the property of CrisisCare Counselling.

General Information

Date: _____

How Did You Learn of Our Services? _____

Are You Requesting Faith Based Counselling? Yes No

Name: _____ Male Female Age _____ DOB _____
Last Name First Name

Contact Information

Post Office Box: _____ Suite or Apt. #: _____
Street Address: _____ City: _____ Postal Code _____
Home Phone: () _____ May We Leave a Message Here: Yes No
Work Phone: () _____ May We Leave a Message Here: Yes No
Mobile Phone: () _____ May We Leave a Message Here: Yes No
Fax: () _____ May We Leave a Message Here: Yes No
Email Address: _____ May We Send a Message Here: Yes No

Employment Information

Employer: _____ Length of Employment: _____
Occupation: _____ Average Hours Worked per Week: _____

Employee Assistance Plan:

Are You Covered by an Employee Insurance/benefits Plan? Yes No
Name of (EAP) Employee Assistance Plan or Insurance Co. _____

Relational Information

Current Marital Status: Single Engaged Married Separated Divorced Widowed Common Law
If Married or Common Law, for How Long: _____
Number of Previous Marriages or Common Law Relationships You _____ Partner? _____
If Separated or Divorced, How Long: _____ If Widowed, How Long: _____
With Whom Do You Currently Live (Check All That Apply):
 Alone Spouse Children Parent(s) Sibling(s) other: _____

Partner Information

Name: _____ Male Female Age _____ DOB _____
Last Name First Name
Work Phone: () _____ May We Leave a Message Here: Yes No
Mobile Phone: () _____ May We Leave a Message Here: Yes No
Email Address: _____ May We Send a Message Here: Yes No
Employer: _____ Length of Employment: _____
Occupation: _____ Average Hours Worked per Week: _____
How Many Hours a Week Do They Work: _____

Children

List Your Children (Living or Deceased)

First Name	Sex	Age	Relationship to You (Circle)	Living with You?
	M F		Natural Step Adopted Deceased	Yes No
	M F		Natural Step Adopted Deceased	Yes No
	M F		Natural Step Adopted Deceased	Yes No
	M F		Natural Step Adopted Deceased	Yes No
	M F		Natural Step Adopted Deceased	Yes No

Family of Origin (Mother, Father, Siblings)

	You	Partner
Father	<input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law	<input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law
Mother	<input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law	<input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law

Brothers	# ___ Natural	# ___ Step	# ___ Adopted	# ___ Natural	# ___ Step	# ___ Adopted
Sisters	# ___ Natural	# ___ Step	# ___ Adopted	# ___ Natural	# ___ Step	# ___ Adopted

Medical Information

Primary Physician: _____ Phone: () _____

Are You Currently Receiving Medical Treatment: Yes No

If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments You've Had

Has Your Weight Changed in the Last 2-3 Months: Yes No

List Any Anti-depressant or Anti-anxiety Medication

Medication	Dosage (Mg)	Improves, Prevents or Controls My	How Long Have You Been on this Medication? (Months)

Are You Taking These Medication(s) According to Your Doctor's Recommendations: Yes No

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?) _____

What Do You Hope to Gain or Change by Coming for Counseling: _____