**Beaches Mental Health**
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# Client Intake & Referral Package

Thank you for choosing **Beaches Mental Health**. We believe seeking support is a meaningful step toward greater wellbeing, connection, and resilience.

At Beaches Mental Health, we take a **"no wrong door" approach** to mental health care. We recognize that every person's journey is unique, and support should meet you where you are. Our goal is to provide compassionate, ethical, and individualized care that supports your mental wellness, strengthens your skills, and helps you navigate life's challenges.

# About This Intake Package

Thank you for choosing **Beaches Mental Health**. This intake package is designed to help us better understand your needs, goals, preferences, and the type of support that may be most helpful for you.

Mental health care is not one-size-fits-all. The information you provide helps us begin to understand your unique experiences and connect you with the appropriate clinician and services.

This intake package includes:

- **Client Information Form** — basic information to help us connect with you and understand your preferred method of communication.
- **Reason for Referral & Current Concerns** — an opportunity to share what brings you to counselling, what areas of life you would like support with, and how you are currently supporting yourself.

- **Consent & Acknowledgement Forms** — important information about confidentiality, the counselling process, and your rights and responsibilities as a client.

## Confidentiality & Privacy

At **Beaches Mental Health**, we are committed to protecting your privacy and creating a safe, respectful environment where you can share openly. Information shared throughout the intake process and during counselling sessions is kept confidential and handled with care in accordance with applicable professional standards and privacy legislation.

Your personal information will only be accessed by the clinicians and administrative team members who require it to provide, coordinate, and support your care. Information will not be shared with others without your informed consent, except in situations where disclosure is required or permitted by law.

## Referral Information

**How Did You Hear About Beaches Mental Health?**

☐ Self-referral ☐ Family/friend referral ☐ Physician/healthcare provider
☐ School/community organization ☐ Workplace/EAP referral ☐ Other: _____

### Referring Individual/Organization (if applicable)

Name: _____

Organization: _____

Phone/Email: _____

Relationship to Client: _____

# Client Information

Full Name: _____

Preferred Name: _____

Date of Birth: _____

Pronouns (optional): _____

Phone Number: _____

Email Address: _____

Preferred Method of Contact:

☐ Phone ☐ Email ☐ Text

Preferred Language: _____

# Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

# Reason for Seeking Support

**What brings you to Beaches Mental Health at this time?**

**What are your current concerns or challenges?**

☐ Stress ☐ Anxiety ☐ Depression/mood concerns ☐ Life transitions ☐ Relationships
☐ Family concerns ☐ Parenting support ☐ Trauma/life experiences ☐ Grief and loss
☐ Burnout ☐ Workplace concerns ☐ Personal growth ☐ Other:_____

**Please describe:**

# Your Goals for Support

**What would you like to gain from counselling?**

**What would feeling better or more balanced look like for you?**

# Whole-Person Wellness

At Beaches Mental Health, we recognize that stress and life experiences affect our **mind, body, emotions, and behaviours**.

Please share anything you would like us to understand about:

### Thoughts & Emotions

### Physical Wellbeing

### Behaviours, Habits, or Coping Strategies

### Relationships & Support Systems

# Previous Mental Health Support

**Have you received counselling or mental health support before?**

☐ Yes ☐ No

**What was helpful?**

**What was not helpful?**

# Current Supports

**Are you currently connected with any of the following?**

☐ Physician
☐ Psychiatrist
☐ Other therapist/counsellor
☐ Community supports
☐ Family/friends
☐ Other: _____

# Service Preferences

**What type of support are you interested in?**

☐Counselling services ☐ Consultation services ☐ Other: _____

**Preferred appointment format:**

☐ In-person ☐ Virtual ☐ Either

**Preferred availability:**

☐ Morning ☐ Afternoon ☐ Evening

# Therapist Matching

At Beaches Mental Health, we believe the therapeutic relationship is an important part of successful care. We will consider your needs, goals, preferences, and availability when connecting you with a clinician.

**Are there any preferences you would like us to consider?**

# Payment & Coverage Information

Payment Method:

☐ Private pay ☐ Extended health benefits ☐ Workplace/EAP coverage
☐ Third-party referral ☐ Other: _____

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*Need some help with the intake package? Please contact a member of our team. We can set up a phone or virtual appointment to complete the package with you (subject to intake team availability).*

# Thank You

Thank you for trusting **Beaches Mental Health** with your wellness journey.

Just as every wave is different, every person's path is unique. Our role is to provide the support, tools, and connection needed to help you navigate life with greater confidence, resilience, and balance.

# Consent & Acknowledgement

By signing below, you authorize **Beaches Mental Health** to collect, review, and share the information contained within this intake package with members of the Beaches Mental Health intake team and appropriate clinical staff involved in assessing and coordinating your care.

This consent allows the intake team to discuss relevant information internally for the purpose of determining appropriate services and supporting your connection to mental health care.

Information will only be shared on a need-to-know basis and will be handled in accordance with applicable privacy legislation and professional standards.

**Your Rights**

You understand that:

- Providing information in this intake package is voluntary.
- You may ask questions about how your information is collected, used, and stored.
- You may withdraw your consent to the collection, use, or sharing of your information at any time, subject to legal and professional obligations.
- Choosing not to provide certain information may affect our ability to determine the most appropriate services or support options.

**Consent**

I confirm that I have read and understand the purpose of this consent. I authorize **Beaches Mental Health** to collect, review, and share the information provided in this intake package with the intake team and appropriate clinical staff for the purpose of exploring, coordinating, and providing mental health services.

Client Name: _____

Signature: _____

Date: _____