VAUGHAN PHYSIOTHERAPY CLINIC

- **Web** vaughanphysiotherapy.com
- **Tel** (905) 669-1221
- **Fax** (905) 669-6995
- **Email** info@vaughanphysiotherapy.com
- **Address** 398 Steeles Ave W, Unit 201, Thornhill, ON L4J 6X3

Scan for your patient portal: book, forms and receipts

Psychotherapy Intake

Get better today.

About You

New to the clinic? Please also complete the New Patient Intake. Fields marked * are required.

First name *		**Last name ***	
Preferred name		**Date of birth * (yyyy-mm-dd)**	
Pronouns		**Mobile phone ***	
Email *		**Emergency contact, relationship and phone ***	
Family doctor		**Doctor's phone or fax**	
How would you like to meet? *	○ In person at the clinic ○ Virtual (video) ○ Either is fine		
OK to leave a voicemail or text? *	○ Yes, either ○ Text only ○ Voicemail only ○ Neither, call me back only		
Referred by	☐ Self ☐ Doctor ☐ VPC clinician ☐ Lawyer ☐ Insurer / case manager ☐ Other		

What Brings You In

Tick all that apply. Share only what you are comfortable with. We will talk about it together at your first session.

What would you like help with? *	☐ Persistent dizziness (PPPD) ☐ Chronic or persistent pain ☐ Stress after an accident or injury ☐ Driving or travel anxiety ☐ Worry or anxiety ☐ Low mood ☐ Sleep ☐ Coping with a health condition ☐ Work or school stress ☐ Relationships or family ☐ Grief or loss ☐ Anger or irritability ☐ Alcohol, cannabis or other substances ☐ Other
In your own words, what is going on? *	
How long has this been a concern?	○ Less than 3 months ○ 3 to 12 months ○ 1 to 5 years ○ More than 5 years
What would you like to be different after therapy?	

Background

Seen a counsellor, psychotherapist, psychologist or psychiatrist before?	○ Yes ○ No	**If yes, who and when, and was it helpful?**	
Seeing anyone now for your mental health?	○ Yes ○ No	**Who (name and role)**	
Any mental health diagnosis you have been given (optional)			
Medications for mood, sleep, pain or nerves			
Alcohol, cannabis or other substances	○ None ○ Now and then ○ Weekly ○ Most days *This helps us plan, not judge.*		
Who supports you? (family, friends, community, faith)			

Patient name:		Date (yyyy-mm-dd):	

If you are in crisis or thinking about suicide, do not wait for your appointment. Call or text **9-8-8** (Suicide Crisis Helpline, 24/7), call **911**, or go to the nearest emergency department. Forms, portal messages and email are **not** checked around the clock.

Safety Check

Everyone is asked these questions. Your answers help your therapist support you safely.

1. In the past month, have you had thoughts of ending your life or of hurting yourself?	○ Yes ○ No
2. Have you ever acted on thoughts of ending your life or hurting yourself?	○ Yes ○ No
3. Do you have any worries about your safety at home or in a relationship?	○ Yes ○ No
4. Have you had thoughts of harming someone else?	○ Yes ○ No

If you answered Yes to any of these, thank you for telling us. Your therapist will talk with you about it at your first session.

Paying for Your Sessions

Many extended health plans cover a Registered Psychotherapist (RP). Please check your plan first.

Paying by *	☐ Paying myself ☐ Extended health insurance ☐ Car accident (MVA) ☐ Employee assistance program (EAP) ☐ Other		
Insurance company		**Policy / certificate #**	
Does your plan cover an RP?	○ Yes ○ No ○ Not sure *Ask your insurer: "Is a Registered Psychotherapist covered, and what is my yearly maximum?"*		

Car Accident (MVA) Only

Complete this section if your sessions are for a motor vehicle accident.

Date of accident * (yyyy-mm-dd)		**You were the ***	☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist
Auto insurer *		**Claim # ***	
Adjuster name *		**Adjuster phone / email ***	
Lawyer (if any)		**Lawyer phone / email**	
Case manager (if any)		**Case manager phone**	
Has a psychologist or doctor assessed you since the accident?	○ Yes ○ No	**If yes, who and when**	
Has your insurer said your claim is in the Minor Injury Guideline (MIG)?	○ Yes ○ No ○ Not sure	**Other treatment for this accident**	☐ Physio ☐ Chiro ☐ RMT ☐ Other

I confirm this information is accurate to the best of my knowledge, and I will tell my therapist if anything changes.

Signature		Date	

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Psychotherapy Consent

Get better today.

Patient name *		**Date of birth ***	

1. About Psychotherapy

Psychotherapy at Vaughan Physiotherapy Clinic is provided by a Registered Psychotherapist (RP) who is a member of the College of Registered Psychotherapists of Ontario (CRPO). Sessions use talk-based approaches such as cognitive behavioural therapy (CBT), skills from dialectical behaviour therapy (DBT), emotion-focused therapy and motivational interviewing. Your therapist will explain what they recommend, why, and what else you could try.

Therapy often helps, but results are not guaranteed. Talking about hard things can bring up strong feelings, and you may feel worse for a short time before you feel better. You can ask questions, set the pace, say no to any part of therapy, or stop at any time.

2. Your Privacy

Your personal health information is collected, used and shared only to provide your care, to bill for it, and as the law allows or requires, under Ontario's Personal Health Information Protection Act (PHIPA). What you say in therapy is kept private, with these exceptions where your therapist may have to share information without your consent:

- If there is a serious risk that you or someone else will be harmed, to help keep people safe.
- If there are reasonable grounds to suspect a child is, or may be, in need of protection. This must be reported to a children's aid society.
- If you tell us that another regulated health professional sexually abused you. This must be reported to their college. Your name is only included with your written consent.
- If abuse of a resident of a long-term care home or retirement home is suspected.
- If a court order, summons or warrant requires records or testimony.
- If the CRPO reviews your therapist's practice, as part of its quality and complaint processes.

Wherever possible, your therapist will talk with you first.

3. Your Records

Your therapist keeps notes of each session in your clinic chart. Your session notes are not shared with your other clinicians at the clinic unless you agree (see section 8). Front desk staff can see what they need for booking and billing only. Records are kept for at least 10 years after your last visit (or 10 years after you turn 18, if later). You can ask to see or get a copy of your record.

4. Contacting Us Between Sessions

Email, text and portal messages are for booking and short practical questions only. They are not checked around the clock and are not secure for emergencies. **In a crisis, call or text 9-8-8, call 911, or go to your nearest emergency department.** I agree to be contacted by email and text for reminders, receipts and forms, and I can opt out at any time.

5. Fees, Insurance and Cancellations

Session fees are posted at the front desk and on our website. Receipts show your therapist's name, RP designation and CRPO registration number for your insurance claim. If a claim is declined, I am responsible for paying for the sessions I received.

I will give at least **48 hours' notice** to cancel or reschedule. Sessions cancelled or rescheduled with less notice, and missed sessions, are charged the full session fee to the card on file. Arriving late shortens the session; it still ends at the booked time.

Patient name:		Date (yyyy-mm-dd):	

6. Car Accident (MVA) and Other Third Parties

If my sessions are paid by an auto insurer, an employee assistance program or another third party, I agree that my therapist may share what that payer needs to approve and pay for my care. For a car accident claim this includes treatment plans (OCF-18), invoices (OCF-21), progress updates and, if requested, my records. My therapist will share only what is needed. I can ask what was sent.

7. Virtual Sessions

If I choose virtual sessions, I understand and agree that:

- Sessions use a secure, encrypted video platform (Juvonno Telehealth). No one may record a session, me or my therapist, without the other's written consent.
- I will join from a private place where I cannot be overheard, and I will tell my therapist where I am at the start of each session.
- If the video drops, my therapist will call me at the phone number on file. If we cannot reconnect, we will rebook.
- Virtual care has limits: some details are harder to notice by video, and no technology is fully secure.
- If I am outside Ontario, my therapist may not be able to see me that day, because rules differ by province and country.
- If my therapist believes I am at serious risk during a session, they may contact emergency services near my location or my emergency contact.

Usual location for virtual sessions (address)			
Nearest hospital		Emergency contact (name, phone)	

8. Working with Your Care Team

Many people see our physiotherapy and vestibular team at the same time. Working together often helps, but it is your choice. Please tick one:

☐ **Yes**, my therapist may share and discuss relevant information with my other clinicians at Vaughan Physiotherapy Clinic

☐ **No**, please keep my psychotherapy separate

☐ Also OK to send updates to my family doctor

9. Students and Supervision

Your therapist may discuss your care, without your name, with a clinical supervisor or peer consultant, as part of good practice. No student will take part in your sessions without asking you first.

☐ **I have read, understood and agree to sections 1 to 9 above.** I have had the chance to ask questions. I can withdraw my consent at any time by telling my therapist.

Signature *		Date *	

If signing for someone else (substitute decision-maker)					
Name		Relationship		Phone	

Therapist signature		CRPO #	

Office use					
Chart #		Entered in Juvonno by		Date	

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Psychotherapy Questionnaires

Get better today.

Patient name:		**Date (yyyy-mm-dd):**	

These questionnaires help your therapist understand how you are doing and track progress. There are no right or wrong answers. **They are not monitored in real time.** If you are having thoughts of ending your life, call or text **9-8-8** or call **911** now.

Mood (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all 0	**Several days 1**	**More than half the days 2**	**Nearly every day 3**
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

If you checked off any problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Office use: PHQ-9 total (0 to 27; item 9 above 0: therapist to review same day)		**Reviewed by**	

Worry (GAD-7)

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all 0	**Several days 1**	**More than half the days 2**	**Nearly every day 3**
1. Feeling nervous, anxious, or on edge	○	○	○	○
2. Not being able to stop or control worrying	○	○	○	○
3. Worrying too much about different things	○	○	○	○
4. Trouble relaxing	○	○	○	○
5. Being so restless that it is hard to sit still	○	○	○	○
6. Becoming easily annoyed or irritable	○	○	○	○
7. Feeling afraid, as if something awful might happen	○	○	○	○

If you checked off any problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Office use: GAD-7 total (0 to 21)		**Reviewed by**	

PHQ-9 and GAD-7: developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Patient name:		Date (yyyy-mm-dd):	

Pain (PEG)

Skip this section if pain is not a concern for you. Fill in one circle on each line.

	0	1	2	3	4	5	6	7	8	9	10
1. What number best describes your **pain on average** in the past week?	○	○	○	○	○	○	○	○	○	○	○
	0 No pain										Pain as bad as you can imagine 10
2. What number best describes how, during the past week, pain has interfered with your **enjoyment of life**?	○	○	○	○	○	○	○	○	○	○	○
	0 Does not interfere										Completely interferes 10
3. What number best describes how, during the past week, pain has interfered with your **general activity**?	○	○	○	○	○	○	○	○	○	○	○
	0 Does not interfere										Completely interferes 10

Office use: PEG average total (0 to 10)		Reviewed by	

Dizziness and Daily Life

Skip this section if dizziness is not a concern for you. Your vestibular therapist may ask you to complete other dizziness questionnaires too.

	0	1	2	3	4	5	6	7	8	9	10
1. On average in the past week, how **bothersome** has your dizziness or unsteadiness been?	○	○	○	○	○	○	○	○	○	○	○
	0 Not at all										Extremely 10
2. How much does **worry about getting dizzy** stop you from doing things?	○	○	○	○	○	○	○	○	○	○	○
	0 Not at all										Completely 10
3. What makes it worse? Tick all that apply.	☐ Standing or walking ☐ Busy places / stores ☐ Screens / scrolling ☐ Moving traffic ☐ Being a passenger ☐ Stress ☐ Tiredness ☐ Other										

Driving and Travel

Complete this section if you have been in a car accident, or if driving or travel has become hard. In the **past month**, how true is each statement?

	Not at all 0	A little 1	Moderately 2	Quite a bit 3	Extremely 4
1. I avoid driving, or drive much less than before	○	○	○	○	○
2. I feel tense or panicky as a driver	○	○	○	○	○
3. I feel tense or panicky as a passenger	○	○	○	○	○
4. I avoid highways, certain roads or the place where it happened	○	○	○	○	○
5. Seeing or hearing about car crashes upsets me	○	○	○	○	○
6. I get dizzy, unsteady or uneasy in busy places, stores or with screens and moving traffic	○	○	○	○	○

Are you driving now?	○ Yes, as usual ○ Yes, but less ○ No ○ I did not drive before
Anything else you want your therapist to know?	

PEG: Krebs EE et al., J Gen Intern Med 2009. Dizziness and driving items are VPC clinic questions, not scored tests.

Patient name:		Date (yyyy-mm-dd):	

Stress After an Accident or Event (PCL-5)

Complete this page if you have been through a car accident or another very stressful event. You do not need to describe what happened.

The event was	☐ Car accident ☐ Workplace injury ☐ Fall or other injury ☐ Health scare / hospital stay ☐ Other	When (yyyy-mm)	

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month**.

In the past month, how much were you bothered by:	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
1. Repeated, disturbing, and unwanted memories of the stressful experience?	○	○	○	○	○
2. Repeated, disturbing dreams of the stressful experience?	○	○	○	○	○
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	○	○	○	○	○
4. Feeling very upset when something reminded you of the stressful experience?	○	○	○	○	○
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	○	○	○	○	○
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	○	○	○	○	○
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	○	○	○	○	○
8. Trouble remembering important parts of the stressful experience?	○	○	○	○	○
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	○	○	○	○	○
10. Blaming yourself or someone else for the stressful experience or what happened after it?	○	○	○	○	○
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	○	○	○	○	○
12. Loss of interest in activities that you used to enjoy?	○	○	○	○	○
13. Feeling distant or cut off from other people?	○	○	○	○	○
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	○	○	○	○	○
15. Irritable behavior, angry outbursts, or acting aggressively?	○	○	○	○	○
16. Taking too many risks or doing things that could cause you harm?	○	○	○	○	○
17. Being "superalert" or watchful or on guard?	○	○	○	○	○
18. Feeling jumpy or easily startled?	○	○	○	○	○
19. Having difficulty concentrating?	○	○	○	○	○
20. Trouble falling or staying asleep?	○	○	○	○	○

Office use: PCL-5 total (0 to 80)		Reviewed by	

PCL-5 (Weathers, Litz, Keane, Palmieri, Marx and Schnurr, 2013), National Center for PTSD. In the public domain. A score is a screen, not a diagnosis.