Client #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Waitlist Folder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Psyc 531 assessment, if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **TELEPHONE INTAKE GUIDELINES-ADULT**

## Greeting:

## Hello, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_. I’m calling from the Psychology Clinic at UBC. I am calling because you recently contacted our clinic about getting some help with problems you're experiencing. The purpose of my call is to get some more information from you so that we can determine whether our clinic is a good match for the kinds of difficulties you are coping with. Is this still a good time for you or would you rather that we reschedule this call for a more convenient time? *[Reschedule for another time if not convenient. Otherwise proceed with the following:]*

## Brief Description of Clinic & Referral Process

Before we begin I would like to tell more about our clinic. We are a specialized training clinic in the department of psychology at UBC. All of our therapists are students who are in training and working towards their PhD in clinical psychology. All of our student therapists are closely supervised by qualified psychologists who are professors here at UBC. Clients benefit from the expertise of both the student therapist and their supervisor who helps ensure you receive the best treatment possible.

You should also be aware that because we are a highly specialized clinic we do not have a traditional waiting list where you are added to the bottom and at some point are guaranteed to reach the top of the list and receive treatment. Instead, people are added to our waiting list and when a therapist has an opening they select someone from the list who has the specific types of difficulties they are providing treatment for at that particular time. For this reason, there is no absolute guarantee that people on our waiting list will get treatment and we cannot provide an estimate of how long the wait will be. However, regardless of whether our clinic is a match for the issues you are seeking treatment for, I will give you the names and contact information of other suitable resources that would be a good match. That way, even if you are on our waiting list you are free to pursue other options in the meantime. Considering this, are you still interested in being considered for treatment at our clinic?

**Screening Questions:**

Are you currently or do you expect to be involved in any **legal proceedings**?

(If yes, find out whether presenting problem is in any way related to proceedings. May need to explain limits of confidentiality, reduced likelihood of services, alternative resources). (If hoarding is presenting problem, query re: threat of eviction: how imminent is it? Possible legal proceedings associated with threat of eviction would not necessarily exclude a client).

Our clinic is open Monday through Friday from 8.30 - 4.30 pm and our psychologists only supervise students during those times. Would you be available to attend treatment sessions during these times? (Note any limitations in client’s schedule)

**Confidentiality**

I also want to let you know that the information you share with me is strictly confidential with a few exceptions:  
1. Because this is a training clinic, your file may be accessed and discussed by faculty and students directly involved with the clinic.  
2. For safety reasons, if you tell me that you are at immediate threat to yourself or others, I may need to break confidentiality. Also, if you tell me that a child is being harmed or is at risk of being harmed then I am required by law to report this information.

Are you still willing to proceed?

I will be asking you several questions today. Please note that you are free not to answer any questions that make you uncomfortable or you would simply prefer not to.

**CLIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred pronoun (she/he/they/other pronoun?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_ Sex assigned at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## TELEPHONE: (home) \_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_

**OCCUPATIONAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONTACT PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENTING PROBLEM: (record symptoms under appropriate categories)**

Can you tell me about the difficulty you are seeking help for and how it is interfering with your day-to-day life at this time?

Mood Symptoms:

How is this difficulty affecting you emotionally (e.g., sadness, anger, fear, frustration)?

Cognitive Symptoms:

Are there certain thoughts that trouble you or tend to go through your mind when you are \_\_\_\_\_\_\_\_\_\_ (anxious, feeling down, etc.)?

Physical Symptoms:

Do you experience troubling physical symptoms when you are \_\_\_\_\_\_\_\_\_\_ (anxious, feeling down, etc.) (e.g., heart palpitations, shortness of breath, sleep disturbances, fatigue)?

Behavioural Symptoms:

Do you find that you avoid certain things/places? Have you have been withdrawing from others?

### Coping Mechanisms:

What have you been doing up to this point to help you cope with these issues?

When did these difficulties start?

How have these difficulties changed over time (i.e., course, severity, etc.)?

What prompted you to seek treatment at this time?

Trauma

Have you ever experienced a traumatic event? For example, have you ever experienced an event in which you felt that your life or personal integrity, or that of someone you cared about, was threatened?

If so:

At this time, do you feel that your experience continues to trouble you or that it would be relevant to the treatment you are seeking now?

Suicidality : (based on the Columbia Suicide Severity Rating Scale)

Have you ever wished that you were dead or wished you could go to sleep and not wake up?

Have you ever had any thoughts of killing yourself? (If yes) When was this?

Whether the client's ideation was past or present, assess the following:

How often do/did you have these thoughts?

How long do/did the thoughts go on for?

Were/are you able to stop thinking about killing yourself or wanting to die if you try to?

Have you ever thought about how you might kill yourself?

(If yes) What did/do you plan to do? Do you have any intention of acting on that plan?

Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide? (assess reasons for living)

Have you ever made a suicide attempt?

If yes, assess for lethality:

What did you do (means)?

What happened (concealment/hospitalization)?

Have you ever been hospitalized following a suicide attempt or for suicidal thoughts?

If the client expresses current suicidal ideation/behaviour, discuss safety precautions, ensure that the client has the 24-hour crisis phone number (604-872-3311), and notify your clinical supervisor immediately. See the TA manual for more detailed recommendations.

Self Harm

Have you ever done anything (else) to harm yourself physically without intending to kill yourself? (if unclear, you can provide cues such as cutting, head-banging, or burning yourself.)

Assess current status, frequency, duration, controllability, lethality:

Were you/Have you ever been hospitalized following an episode of non-suicidal self-injury?

* If self-harm is current and potentially lethal, discuss safety precautions, ensure that the client has the 24 hour crisis phone number (604-872-3311), and notify your clinical supervisor immediately. See the TA manual for more detailed recommendations.

Substance Use

Next I have a few questions for you about your use of various substances.

On average, how much caffeine do you drink per day?

How much alcohol do you drink per week?

If person drinks:

What is the maximum you would drink in one sitting?

What type of alcohol do you typically drink?

Do you currently use any other drugs?

If so, assess what person uses, how much, how often.

At this time, does your substance use negatively impact your life in any way?

Was there ever a time where you drank alcohol or used another drug heavily in the past?

If so, assess what person was using, how much, how often, and how long the period of heavy use lasted.

Did you ever receive treatment for your use of substances?

Sexual Identity

The next few questions will be about your sexual and romantic attractions, and gender identity. We ask so that we can provide clients with the most informed, competent care possible. Some people strongly identify with a particular sexuality, while others may not and experience their sexuality as fluid or changing over time. Our clinic is supportive of people with LGBTQ+ identities, and I can assure you we do not view any sexual orientation as a mental health problem. We understand that it may be an issue for other people in your life, and we can address that with you.

How would you describe your sexual attraction to others at this time of your life?

Who are you romantically attracted to (usually)?

Gender Identity

Just like with sexuality some people experience their gender as fluid, whereas others have one, relatively stable gender identity over time or transition to that new stable gender idenity.

How would you describe your gender at this point?

Is there anything else about your sexuality or gender that you’d like your therapist to know?

Intimate relationships:

At this time, do you consider yourself to be in a committed relationship?

Is your partner aware of these difficulties? (If so, ask about motivation & insight of partner).

How do these difficulties impact your relationship with your partner?

Do you have other social supports or friends?

Other important information:

What are your goals for treatment?

Are you **currently** receiving any help for your difficulties? (if yes, describe)

Have you received any help or treatment for these difficulties in the **past**?

(if yes, describe what, how much, successful? – why?)

Have you ever been **hospitalized** for these difficulties? (if yes, describe)

Are you currently taking, or have you ever taken, any **medications** for these difficulties?

Quality of **verbal presentation** (e.g., organization, psychological mindedness/insight, motivation, English fluency):

Would you be interested in having an assessment done at our clinic (feedback would be provided) by one of our students, even if we cannot offer treatment? **Yes/No**

Because our clinic is part of an academic institution, there are sometimes research studies being conducted within the clinic. The results of these studies can be used to increase knowledge about mental health challenges or improve psychological treatments. Usually, participating in these studies involves filling out questionnaires. Would you be willing to be contacted about participating in future research studies? **Yes/No**

(**If prospective clients have concerns about privacy or access to treatment, you can add the following:** Your responses would be anonymous, as the questionnaires do not ask you for information that can reveal your identity. Participation in research is voluntary, and your decision to participate or not participate will not affect your ability to get into treatment here.)

Would you be interested in receiving treatment in a group format? **Yes / No**

**Add this for clients interested in group therapy:** Some groups are part of a research study as well, meaning there would be some additional self-report measures to fill out during your course of therapy. Would that be OK? **Yes/No**

**FEE ASSESSMENT**

Although we are a student training clinic, we do have nominal fees on a sliding scale depending on your income. We have 4 categories: first, household incomes that are under $20,000 per year; second, between $21 - $40,999; third, between $41,000-$61,000 and fourth, above $61,000. Which income bracket do you fall into?

**ASSESSMENTS & TREATMENT**

***(Individual, Family, and Group Therapy)***

Yearly Household Income Fee

before taxes

<$20,000 $15/session

$20,000 – $40,999 $20/session

$41,000 – $61,000 $35/session

>$61,000 $50/session

***Group Therapy***

Yearly Household Income Fee

before taxes

<$20,000 $10/session

$20,000 – $40,999 $20/session

$41,000 – $61,000 $30/session

>$61,000 $50/session

Is there anything I haven’t covered that you feel would be important for a therapist to know?

Do you have any questions for me?

Team Suggestion: Team’s Rating of Appropriateness (0=never would see, 10=ideal):

Client #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Waitlist Folder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Intake: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_