dreamcatcher™
nature assisted therapy

Dependent Intake

53044 RR #213 Ardrossan, Alberta, T8G 2C4
Ph: (780)-809-1047 Fax: (780)-809-1046
Email: info@dreamcatcherassociation.com
Website: www.dreamcatcherassociation.com

Client Information

Name of Person Completing Intake:		Date Intake Completed:
NAME	DOB: MM/DD/YR	PRONOUNS

Guardian Information

NAME		
SOLE/JOINT Guardianship		
ADDRESS		
PHONE		
ALT. PHONE		
EMAIL		
RELATIONSHIP TO CLIENT		

Caregiver Information – If same as Guardian Information, please advise

NAME		
ADDRESS		
PHONE		
EMAIL		

Are both parents listed legal guardians? Yes ☐ No ☐
Note –If the biological or same sex parents are together or the dependent is a ward of the province, a Guardianship Order is not needed. A Guardianship Order is required if:

- The biological or same sex parents have separated, or the dependent is under the guardianship of an alternate person, such as adoption.
- One person has sole guardianship of the dependent. *Please note, having sole custody does NOT equate to having sole guardianship.

If joint guardianship, *both* guardians must sign consent forms. If the parents are separated but both sign the consent forms, a Guardianship Order is not needed. A parent may not be on the birth certificate but still recognized as a guardian if they resided in the home for a minimum of 1 year and were parenting the child during that time. Please contact the office if you are unsure.
Please note, Dreamcatcher™ may call to gather more information regarding guardianship if needed.

Emergency Contact

Name	
Number	
Relationship to You	

Preferred Time of Day/Day of the Week

	Mon	Tues	Wed	Thurs	Fri
Morning					
Afternoon					
Evening					

Booking

Who is the best person to contact for booking appointments?	
Phone Number	
Relationship to Client	

Funding

Provide Insurance/FSCD/Funder/Treaty Number if you would like us to attempt direct billing. Please note: not all therapists can direct bill and not all insurance allows direct billing		
All Private Client Files must have a current credit card, expiry, and CVV on file. Please list it here	Name on Card:	Expiry:
	Number:	CVV:
Please include any alternative coverage/funding here:		

Medical History

Current Medications, Vitamins, Supplements, Melatonin, Birth Control: Please include current dosage and when it was prescribed.	
Medical Conditions: Please include physical conditions and/or any mental health diagnoses the dependent may have. Ex: asthma, heart murmur, ADHD, eczema, etc.	
Does the dependent have a compromised immune system? Are they sick easily? Any long-term illness?	
Do they have Down Syndrome?	
Do they have any cognitive impairments?	
Do they have any allergies? How are they managed? Do they require an EpiPen?	
Do they have any phobias? Ex: spiders, needles, snakes, etc.	
Are there concerns not listed?	

Reasons for Referral

In this box, please describe the reason your dependent is seeking therapy.

Goals. What would you like to accomplish?

Additional Information

Is there a history of animal abuse? Have they witnessed it? If yes, please explain:		
Have any assessments been completed in the past 2 years? Ex: Psych-Ed assessments or IPP/Service Plans. If yes, please email copies to info@dreamcatcherassociation.com	☐Educational Assessment ☐Psychological Assessment ☐Neurodevelopmental ☐Speech	☐ Medical ☐OT ☐PT ☐ Other:_____
Is there a psychiatrist? If yes, please provide their contact information		
Do you have any other support services? Please provide their name.	☐IPP (date):	☐OT
	☐Medical	☐PT
	☐Therapy/Counselling	☐Speech
	☐CFSA	☐Other
Have they been in therapy before? If yes, when was their last session, how often did they attend and for how long? What type of therapy was it? Was it helpful?		
Are there other therapists currently involved? If yes, please provide their contact information		
Are they open to therapy now?		
Have they ever been hospitalized for mental health reasons?		
Have they ever been admitted to a treatment facility?		
Any extra things we should know about them? Here you can list any likes, dislikes, strengths, weaknesses, hobbies, or interests.		
What therapeutic medium are you most interested in? Animal Assisted*, Equine Facilitated Counselling*, EMDR, Art, Nature Assisted, Sandtray, Music, Talk, Play	*If choosing animal or equine facilitated counselling, please see below for a brief understanding of the initial session.	
How did you hear about us?		

Please note, the initial session serves as a pivotal opportunity for clients and therapists to establish rapport and familiarity within the therapeutic setting. Clients are invited to explore the outdoor therapeutic environment with their therapist and meet our therapy animals, laying the foundation for trust and comfort within the therapeutic alliance. During this session, the therapist conducts a functional assessment to gain deeper insight into the client's needs and preferences, including identifying the animal partner they may resonate with or wish to work with. This assessment informs the development of a tailored treatment plan, ensuring a holistic and client-centered approach to animal-assisted services (AAS) that will meet the therapeutic needs of the client.