Dennis Esayenko

Airdrie Alberta
403-828-2664
email : midwesttrinitycounselling@telus.net

Congratulations on your decision to seek out professional counselling. 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. ***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.***

Dennis Esayenko

Professional Accountability

Dennis Esayenko received an MA in Counselling from Providence College and Seminary in 2006. He has over 35 years experience as a peace officer and while being involved in law enforcement, he has volunteered and worked in the areas of Victims Assistance and in the Peace Officer Peer Support Program of Legacy Place Society. http://legacyplacesociety.com/

Dennis is trained in Critical Incident Stress Management. In 2012, he was awarded the Queens Diamond Jubilee metal for recognition of his service to the community. He is a member in good standing with the Professional Association of Christian Counsellors and Psychotherapists and adheres to their Code of Ethics.

Appointments and Confidentiality

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

Fees:

Cash, Cheque or etransfer

Individual Session . . . .$ 85.00
Couples/Family $100.00

A session is 50 minutes in duration. 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 $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 to begin a formal counseling relationship with Dennis Esayenko. You are agreeing to release, remise and forever discharge and covenant not to sue or hold legally liable MidWest Trinity Counselling, 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

Midwest Trinity Counselling

Confidential
Client Information Form (Child)

Please thoroughly complete the following Confidential Client Questionnaire in preparation for your child's first counselling session. The Questionnaire will assist your counselor in developing a clearer understanding and appreciation for your presenting concerns. Your Questionnaire will be placed in your client file.

Child's Name:__________________ Date of Birth:_______ Sex: ____ M _____ F Age______

Address:____ Postal Code:______________________

Name of Parent/Guardian:______________________________

Home Phone:_______________ Cell Phone:_______________ email: ___________________________

Members of Current Household:

Name	Sex	Age	Relationship to Child

Immediate Family Members not Living in Household:

Name	Sex	Age	Relationship to Child

What Do You Consider to be the Main Problems Which Led to This Referral?_____________________

____

____

____

____

When Did These Problems First Begin?____

Who First Noticed the Problems?____

What Do You Think Has Caused the Child's Problems?____

What Have You Done to Try and Deal With the Problems?_______________________________________

How Have These Problems Affected Your Child at Home and School?____________________________

Family History

List any family members who have been or are currently involved in Psychiatric or Psychological treatment:

Name	Relationship to Child	Reason for Treatment

Children's problems can be affected by or related to other stresses. Has your family experienced any of the following in the past two years:

_____ Separation/ Divorce _____Increase in family conflict _____Death in family
_____Addition to household _____Financial stress _____Illness of family member
_____Change of residence _____Change of school _____Loss/change of job
_____Drug or alcohol abuse _____Other (please specify)_______________________________

Medical/Developmental History

Family Physician_______________________________ Pediatrician______________________________

Other Specialists____

Were there any complications during pregnancy?____
____
____

Were any medications or other substances used? _____ Yes _____No
If yes, explain.____
____
____

Length of pregnancy__________ Length of labour __________

Complications during birth?____
____
____

What was your emotional state throughout your pregnancy? ____________________________________
____

Baby's birth weight__________

Length of hospital stay: Mother_______________ Baby_____________________

Did the mother experience Post-Partum Depression? Yes_____ No_____

For how long? ____How severe?_____________________

Were there problems with:

_____Sucking _____Feeding _____Weight gain _____Vomiting
_____Food refusal _____Sleeping _____Cholic _____Crying
_____Apnea _____Other____

At about what age did your child:

Crawl__________ Walk__________ Speak first words__________

Medical conditions currently affecting your child:____
____
____

Is your child taking any medications? (please list)____
____
____

Please indicate any hospitalizations/ injuries/surgery's:

Description	Age	Length of stay

Has your child ever been separated from the family? Please specify:

Age	Length	Reason	Child's reaction

Does your child become upset around separations that occur in your daily routine?___________________
____
____
____

Does your child have an attachment to a particular object (e.g. blanket or stuffed animal)?_____________
____
____

Behavioral Concerns - Please check only those that were or are a concern to you:

	0-2 yrs	2-5 yrs	6-14 yrs
Temper Tantrums			
Thumb sucking			
Breath holding			
Muscle tics			
Unusual fears			
Destructiveness			
Fire-setting			
Aggressiveness			
Sibling rivalry			
Lying			

Behavioral Concerns - Please check only those that were or are a concern to you: (Cont')	**0-2 yrs**	**2-5 yrs**	**6-14 yrs**
Restlessness			
Stealing			
Excessive sadness			
Self-destructive acts			
Cruelty to animals			
Defiance			
Resistant			
Easily distracted			
Eating problems			
Sleeping Problems			
Mood swings			
Overly compliant			
Nightmares			
Physical complaints			
Immature behavior			
Talk of killing self			
Withdrawn			
Easily frustrated			
Impulsive			

Special Testing	**Age**	**Where**	**Results**
Hearing			
Vision			
EEG (brain waves)			
Neurological			

Allergy			
Psychological			
Speech and Language			
Other			

Developmental Concerns

Did you have concerns about your child's development in any of the following areas?

_____**Gross motor** _____**Speech** _____**Social development**
_____**Fine motor** _____**Cognitive development**

Are any of these areas still a concern for you? ____
____
____
____

Child Management

Who typically disciplines your child?____
____
____
____

What have you found most effective in managing behavior?_________________________________
____
____
____

How does your child react to discipline?____
____
____
____

Is there agreement among adults in your household about methods of child management?_____________
____
____
____
____

Child Care School Experiences:

Early child care provided by	Age

School	**Grade**

Has your child been involved with any of the following:

Special education	Grade
Psychological service/ assessment	
Behavioral adjustment class	
Tutoring	
Other	

Does your child like school?____
____
____
____
____

This form completed by: ________________________ _____Parent _____Guardian _____Other

(If other, please explain____

Name____________________________________ Date_____________________________
(Please Print)

____
Signature