Empathic Guidance 2023

Somatic Mystic Guide, informed & trained in:

- Psychology & Clinical Counselling.
- Somatic Experiencing,
- Meditation, Companioning,
- Trauma Recovery,
- Spiritual Coaching,
- Grief Counselling
- Energy Modalities including training in Shamanism

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Working with me involves an agreement made between yourself and I. You are the expert of you, and I am learning about you every moment I am with you. I value My relationship with my clients and believe that such a relationship is the beacon in the healing process. I am not interested in taking your money just because, I am invested in the relationship that is needed to promote healing.

I have extensive experience in the area of Grief and support individuals who are navigating transitional, separational, trauma and bereaved grief. I am an Internationally licensed Greif and Trauma Counsellor with over 17 years of experience specializing in various counselling methods.

As a Somatic Experiencing Practitioner, I facilitate all my offerings from a Somatic Foundation. With training in areas including Syndromes, Generational and Intergenerational Trauma, Medical Trauma, and Mortal Threat and Near-death experiences.

Everyone is unique and has their own way of addressing resolutions. I work in a wellness model that helps my clients empower themselves by focusing on what works for them and not on a systematic approach that provides a generic procedure for working on a treatment. I appreciate our difference and look forward to each opportunity to be with you on your journey.

All my offerings involve a friendly witness, listening in compassion and acceptance. This involves asking questions, offering information, sharing resources and guidance in many areas.

If I am unable to support your journey, I will inform you and assist in you finding someone who is.

It's important to note here that what happened to you in your life and could have significantly influenced your current symptoms or behaviours. Attending to these more hysterical questions can open a window to more beneficial and lasting treatment.

Client's Rights

1. The client may ask questions about what to expect during and the possible end result of the therapy.
   - decline to proceed with the therapy as to the techniques which may be conducted by the therapist.
   - cease to continue therapy anytime, without any impediment and may return to therapy anytime.
   - to review his or her records from the therapist.
2. The therapist has the right to dismiss the client from the course of therapy.
3. Right to confidentiality: Within limits provided for by law. These limits are concerning intent to harm.
   a. If you disclose to me that you intend to harm yourself/to take your life, I am obligated ethically to take the necessary steps to ensure your safety. Initials
   b. If you disclose to me information regarding harm to a child or vulnerable person, I am obligated to contact the authorities. Initials
      If my records are supposed by law, I am obligated to hand all records over. Initials
   c. If you authorize sharing of records, then we will discuss what is shared together prior to my sending any information. Initials
4. All records and information acquired by the therapist shall be kept strictly confidential in accordance with the principles of a doctor-patient relationship. All information will not be shared or revealed to any person, agency, or organization without the prior written consent of the client.
5. The client can raise any concerns and to speak with the therapist immediately of any concerns provided that the therapist is likewise available to discuss matters with the client.

Signature

Informed Consent

I understand that results might vary, and that Mj (Myrna) LeBlanc may not guarantee results. What Mj (Myrna) LeBlanc offers is not a replacement for medical treatment, psychological or psychiatric services, or psychological or psychiatric counselling. Initials

I understand that Mj (Myrna) LeBlanc does not treat, prescribe, or diagnose any condition. Initials

I understand that Mj (Myrna) LeBlanc is not practicing any other profession that requires a permit/license under the laws of Canada or Internationally. Initials

Collaboration between Mj (Myrna) LeBlanc and myself involves setting goals, planning homework to be done between sessions, commitment to complete agreed upon homework. Initials

I understand that Mj (Myrna) LeBlanc does not guarantee results. Initials

Any participation with Mj (Myrna) LeBlanc is of my own volition, Mj (Myrna) LeBlanc is not liable for any outcome. Initials

I agree to fill out this form & the Intake form attached and email them to Mj LeBlanc Initials

Give 24 hours cancelation notice. Initials

I agree to pay for service at the end of each appointment. Initials

Acknowledgement

I have reviewed this Informed Consent Agreement. Initials

I likewise understand my Client's Rights. Initials

I accept this agreement and consent to counselling. Initials

Client Information

First Name _____ Phone Number _____

Last Name _____ Email _____

Address

Street Address _____ Country _____

City _____ State / Province,_____

Postal Code/Zip _____

PRESENTING PROBLEM:

Please state in your own words the main reason for seeking counseling.

_____

Please estimate the severity of your problems:

On a scale between 1 – 10. With 1 being mild and 10 being extreme.

mildly upsetting ___ very upsetting ___

moderately upsetting ___ extremely upsetting ___

Have you been in counseling before?

If so, please give names and dates of treatment and results.

_____

_____

PERSONAL AND SOCIAL HISTORY

MARITAL STATUS (circle one)

Single Engaged Married Separated Divorced Widowed

Name of your spouse _____ Length of marriage _____

Please list any significant information regarding your relationship.

_____

_____

Children: Please list children by sex, name and age.

1._____ 4._____

2._____ 5._____

3._____ 6._____

If your father is living, what is his age? ___ State of his health & Current relationship.

If your father is deceased, age._____ Cause of death? _____

How old were you at the time? ___ Relationship at death._____

If your mother is living, age? ____ State of her health & Current relationship?

If your mother is deceased, age? ____ Cause of death? _____

How old were you at the time? ___ Relationship at death._____

Please list and identify by name and age your siblings, along with any significant information regarding your relationships.

_____

_____

Please list any mental health history in your family of origin: (It's important to note here that what happened to your parents and grandparents could have significantly influenced your current symptoms or behaviours. Attending to these more hysterical questions can open a window to more beneficial and lasting treatment.)

_____

_____

_____

Signature

Please list any events in your childhood and as an adult that have been particularly challenging:

Please list any events in your childhood and as an adult that you feel may be trauma:

Signature

EDUCATIONAL HISTORY

Highest level of education achieved:

___High school ___undergraduate ____graduate ____doctorial

Major _____ Degree Earned_____

PHYSICAL HEALTH

Do you have any current concerns about your physical health? Yes___ No ___
If yes describe:

Are you currently taking any medications? Yes___ No____ If yes please list medication you are currently taking or have taken in the last six months, include prescription and over the counter medicines.

Do you get regular exercise? If so what type and how often?

Please describe your nightly sleep pattern. Do you regularly get less than 7 hours of sleep or more than 9 hours of sleep?_____ Do you have nightmares on a regular basis?_____

Do you have any sleep disorders?

_____

_____

Please list any concerns you have about your eating habits.

_____

_____

Have you had any weight loss or weight gain in the last 3 months? If so how much?

Behavior – underline or circle any of the following behaviors that apply to you:

Overeat	Take too many	Work too hard	Outbursts of
Suicidal attempts	risks	Procrastination	temper
Can't keep a job	odd behavior	Sleep disturbance	Loss of control
Take drugs	Withdrawal	Crying	Aggressive
Compulsions	Lack of motivation	Impulsive	behavior
Insomnia	Drink too much	reactions	Concentration
Vomiting	Nervous tics	Phobic avoidance	difficulties
Smoke	Eating problems		

Signature

Are there any specific behaviors, actions, habits that you would like to change?

_____

_____

Feelings – underline or circle any of the following feelings that apply to you:

Angry Guilty	Conflicted	Contented	Relaxed
Unhappy	Restless	Fearful Hopeful	Tense
Annoyed	Depressed	Excited	Envious Jealous
Happy	Regretful	Panicky Helpless	Others:
Bored	Lonely Anxious	Optimistic	
Sad	Hopeless	Energetic	

Physical – underline or circle any of the following symptoms that apply to you:

Headaches	Muscle spasms	Unable to relax	Visual disturbances
Stomach trouble	Twitches	Fainting spells	Numbness
Skin problems	Chest pains	Blackouts	Flushes Hearing problems
Dizziness	Tension	Bowel disturbances	Don't like being touched
Tics	Back pain	Hear things	
Dry mouth	Rapid heartbeat	Excessive sweating	
Palpitations	Sexual disturbances	Tingling	
Fatigue Burning or itchy skin	Tremors	Watery eyes	

Are you having any difficulties/stressors in your current job?

_____

_____

_____

_____

Please identify what you hope to accomplish in counseling:

_____

_____

Signature line

Date Signed _____