SOUTHWEST COUNSELLING SERVICES

704 MARA ST.
N7V 1X4, UNIT 207
POINT EDWARD, ONTARIO

519-336-3100
SWCOUNSELLING.CA

CHILDREN'S AID SOCIETY – **CHILDREN'S SERVICES** INTAKE FORM

Thank you for taking the time to complete this intake form. The details of this form are confidential and will be kept in a secure location *(please see confidentiality policy).*

Personal Information

Date:

Name of Child/Youth:

CPIN Client #:

CPIN Case #:

Date of Birth:

Gender: [ ] Male [ ] Female [ ] Other

What is this child/youth's status (e.g. TCA, Society, or Crown Ward):

Primary Caregiver(s) Name(s):

Home (or placement) Address:

Phone Number(s):

May we leave a message? [ ] Yes [ ] No

Email Address:

Children's Worker Name & Contact Information:

Number of Approved Sessions & Billing Contact:

Consent to Receive Child/Youth Social History? [ ] Yes [ ] No

Emergency Contact

Name:

Relationship:

Address:

Phone Number:

Medical Information

Family Doctor:

Please list any other professionals involved with this child/youth (e.g. Psychiatrist):

Please list any other agencies involved with this child/youth (e.g. CMHA):

Diagnosis & Medications (relevant to counseling):

Please list any significant health issues (past or present):

Has this child/youth ever been admitted to hospital for mental health concerns? [ ] Yes [ ] No

Has this child/youth previously participated in counselling or psychotherapy? [ ] Yes [ ] No

Information or concerns regarding any previous therapeutic treatment:

Presenting Concerns

Please describe the reasons for seeking counselling services at this time:

What has occurred already to assist in managing challenges?

Is this child/youth experiencing any of the following, if historical please identify:

[ ] Relationship issues [ ] Financial Strain [ ] Divorce/Separation
[ ] Grief/Loss of loved one [ ] Medical Issues [ ] Domestic Violence
[ ] Physical/Sexual/Emotional Abuse [ ] Legal/Court involvement
[ ] Employment issues [ ] Sadness [ ] Loss/Gain of appetite
[ ] More/Less sleep [ ] Frequent Crying [ ] Loneliness
[ ] Mood swings [ ] Low self-esteem [ ] Loss of Interest in activities
[ ] Anger/Hostility [ ] Excessive Worry [ ] Feelings of panic/fear
[ ] Inability to be calm [ ] Recalling traumatic events or memories
[ ] Nightmares [ ] Re-experiencing trauma [ ] Social Isolation
[ ] Flashbacks [ ] Avoidance of people/places
[ ] Alcohol use [ ] Drug Use [ ] Addictions
[ ] Obsessions [ ] Disordered Eating [ ] Excessive Exercise
[ ] Paranoid Thoughts [ ] Hallucinations (visual or auditory)
[ ] Self-Harm (i.e. cutting, burning) [ ] Thoughts of harming self
[ ] Thoughts of harming others [ ] Suicide Attempt
[ ] Other: _____

Identify goals you would like the child/youth to achieve through therapy:

Policy changes effective October 1, 2017 regarding missed appointments:
First missed appointment (late notice or no notice) will not be charged, but after a second missed appointment, therapy will be put on hold until worker addresses with the referred client(s). The second missed session will be billed.