SOUTHWEST COUNSELLING SERVICES

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# CHILDREN'S AID SOCIETY - **FAMILY 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:

Client(s) Name(s): CPIN Client #:

CPIN Case #:

Date of Birth:

Gender: [ ] Male [ ] Female [ ] Other

Primary Caregiver:

Non-custodial Parent:

Please identify access arrangements:

Home Address:

Phone Number(s): May we leave a message? [ ] Yes [ ] No

Email Address:

Family Worker Name & Contact Information:

Number of Approved Sessions & Billing Contact:

**Emergency Contact**

Name:

Relationship:

Address:

Phone Number:

**Medical Information**

Family Doctor:

Please list any other professionals involved (e.g. Psychiatrist):

Please list any other agencies that are involved (e.g. CMHA):

Please list any diagnoses & medications (relevant to counseling):

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

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

Has this individual participated in counselling or psychotherapy? [ ] Yes [ ] No

Is there current involvement in the criminal or family courts? If so, please explain.

Is there a finalized custody and access order?

Family history that may be relevant for counselling (significant events, losses, trauma):

**Presenting Concerns**

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

What has occurred already to assist in managing challenges?

Is the client(s) 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: _____

What are your goals for therapy? Please specify worker goals and client goals.

*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.*