

CONNECT COUNSELLING & THERAPY SOCIETY INTAKE INFORMATION

FOR OFFICE	Counsellor: _____
USE ONLY	Programs: <input type="checkbox"/> ASTAT <input type="checkbox"/> C&Y <input type="checkbox"/> SIB <input type="checkbox"/> STV <input type="checkbox"/> CC <input type="checkbox"/> EEPS <input type="checkbox"/> CVAP <input type="checkbox"/> FFS
Referral Date: _____	Date Opened: _____

- Please complete this form as best as you can. If you don't understand some of the questions, please ask your counsellor for clarification.
- The information you provide is strictly confidential and will not be shared or released without your written consent except in cases of suspected child abuse and where there is an indication of imminent physical danger to you or others.

► Client's Basic Information (Adult or Child)

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ Age: ____ Gender: Male Female _____
Year Month Day

Ethnic Background: _____ (eg. Caucasian, First Nations, Asian, etc.)

Primary Language: _____ Is an Interpreter Required? Yes No

► (For couples counselling, please add partner's name here)

First Name: _____ Last Name: _____

Date of Birth: ____/____/____ Age: ____ Gender: Male Female _____
Year Month Day

Ethnic Background: _____ (eg. Caucasian, First Nations, Asian, etc.)

Primary Language: _____ Is an Interpreter Required? Yes No

► Address & Contact Information

Address: _____

City/Town/Municipality: _____ Postal Code: _____ Email: _____

Phone Numbers: Home _____ Work _____ Cell _____

Is it safe to leave detailed message at home? Yes No At Work? Yes No On email? Yes No

How far did you travel today to get to our offices? Less than 5 km 5 - 70 km More than 70 km

► Family Members / Guardian Information (for child & youth counselling: include parents, guardians & all siblings of child)

Name	Gender	Relationship with Client	Age	Resides with Client	Involved in this Service
				Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
				Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
				Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
				Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

► Parenting Arrangements (in situations of separation/divorce):

- Sole Guardianship Joint Guardianship

Please describe pertinent parenting arrangements:

► Emergency Contact Information

Name: _____ Address: _____

Relationship: _____ Phone: _____

Is there any emergency medical information we should know about? (allergies, medical conditions)

Comment: _____

► Current Services Accessed: Please list any other services you are currently accessing:

Location/ Organization	Name of Contact	Title	Phone

► Previous Services Accessed

Please list any other services or supports you have accessed in the past:

Type of Service	Length of Involvement	Did this service help?	If yes, how?

► Referral Information

I was referred by:

- | | | |
|----------------------------------------------------------------------|----------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Adult Mental Health /Alcohol & Drug Program | <input type="checkbox"/> Family Doctor | <input type="checkbox"/> Family Member |
| <input type="checkbox"/> Child & Youth Mental Health | <input type="checkbox"/> Website | <input type="checkbox"/> Probation/Parole |
| <input type="checkbox"/> MCFD/Social Worker (Children or Adult) | <input type="checkbox"/> Hospital | <input type="checkbox"/> Community Agency |
| <input type="checkbox"/> Police | <input type="checkbox"/> Friend | <input type="checkbox"/> Other |

► Reason for Referral

In your own words, please describe the reason you have accessed our services:

► What issues are affecting you or your family at this time (Indicate all that apply)

- Anger Issues
- Blended or Step Family Issues
- Child/ Teen Behaviour
- Depression/mood swings
- Parenting Issues
- Family Violence
- Physical Health Issues/pregnancy/disability
- Adjusting to Life Transitions
- Ministry of Children & Family Development Involvement
- Education/employment issues
- Other (describe): _____
- Relationship Issues
- Grief & Loss
- Self Esteem
- Trauma Issues
- Anxiety/ Worry/ Concerns
- Experience of Abuse
- Sexual Behaviour Issues
- Stress Related Issues
- Addiction Issues
- Lack of social support

Are there any urgent concerns we should be aware of? (e.g. legal, suicide, or medical issues)

Yes No

If yes, please describe: _____

Are there any safety concerns we should be aware of? (e.g. issues relating to violence, risk taking behaviors, threats, abuse, harm to self or others?)

Yes No

If yes, please describe: _____

Education and Employment history

Please describe information with respect to you or your family (including literacy level) that you feel is important for us to know.

► Health Information

Are there any physical issues or conditions, past or present, that we should be aware of? If you are here for child and youth counselling, please fill out on behalf of the child

Self Child Yes No

If yes, please describe: _____

Have you had mental health concerns or a mental health diagnoses? Yes No

If yes, please describe: _____

Are you currently taking medications to address the physical or mental health issues described above?

Yes No

If yes, please describe: _____

Have you any concerns about misuse of alcohol or drug use by yourself or within your family? Yes No

If yes, please describe use: _____

Past Issues & Current Challenges

Is there any information with respect to you/ your family that you feel is important for us to know? (childhood abuse/neglect, relationship violence, trauma, family history, significant relationships, living situation)

Culture and Spiritual Beliefs

Please describe information that you feel is important for us to know.

► Strengths, Abilities, & Interests

Please describe any strengths, abilities, supports, or interests that you, or your family has that could help in addressing the issues or challenges you face:

Strengths: _____

Abilities: _____

Supports: _____

Interests: _____

► Service Delivery Preferences

Are there any needs, preferences, or assistive requirements you have with regard to receiving services from the Kelowna Family Centre? If so, please describe:

► Follow-up Permissions

The Kelowna Family Centre appreciates follow-up feedback once service is completed. Please indicate if you would be willing to participate in a brief telephone survey.

Yes No

Client Signature

Date

Counsellor Signature

Date

For child and youth counselling please complete next page

Child's Developmental Issues and Social Environment

<p>Note: This section is only filled out for Child and Youth counselling.</p>	<p>Information provided by family member (Name) _____</p>	<p>Information provided in referral document</p>
<p>1. After school leisure, sports, clubs, and/or community involvement:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>
<p>2. Education/ School information includes the following elements:</p> <p>a. Motor development is age appropriate: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b. Language development is age appropriate: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>c. Hearing function is within normal range: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. Visual function is within normal range: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>e. Intellectual function is age appropriate: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>f. Peer interaction is age appropriate: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>g. Learning ability is age appropriate: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>h. Immunization records are available Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><u>If no</u> (for any of the above), what is the current status and/or what intervention has been done or not done.</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>3. Please provide other pertinent information, for example: school history; special education needs; family and peer relationships; prenatal exposure and/or history of use of alcohol, drugs, and tobacco; trauma/abuse, housing situation:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>

If you require more space please use the back of this form.

CLIENT INFORMATION SHEET

We ask that you please read the following information and sign at the bottom.

Cancellation/No Show Policy:

In our effort to reduce the amount of time clients have to wait for service we ask that if you are unable to keep an appointment that you inform us **24 hours in advance**. This will allow us to fill your time slot with someone from our waitlist. *If you miss two appointments, without notifying us in advance, the administration staff may not be able to re-book you.* It will then be necessary to contact your counsellor for further direction. ***Please do not come if you are sick, we will be pleased to rebook your appointment.***

Limits of Confidentiality:

Your attendance at this office and sessions with a counsellor will be kept confidential. No material or information will be released without your signed consent except under the following conditions:

1. **The Child, Family and Community Service Act** requires that we report to the Ministry for Children and Family Development any disclosure of a child under 19 who is at risk for abuse or neglect.
2. If you share information indicating that you pose a threat to harm yourself or another person, the counsellor will take the necessary action to ensure your safety and/or the safety of others.
3. The counsellor is bound by law to provide information in the following situations:
 - a) Subpoenaed to appear before a court;
 - b) Issued a police search warrant;
 - c) Subpoenaed by a Coroner's Inquiry
4. Your counsellor is required to allow the review of client files for the purpose of clinical supervision and case consultation. Your confidentiality will be protected during this review.
5. Your personal information will be entered into a database (called Counselling Trac). Information is encrypted and stored on an offsite site webserver which is highly secure. *Non-identifying elements* such as survey results *may be* used for agency statistical reporting.

For Parents who have Shared Guardianship:

Please be advised that it is your responsibility to inform the other parent of matters pertaining to your child's health, including the fact that your child is receiving counselling services.

I have read and understood the information contained in the client intake package. I have the right to ask my counsellor any questions or have clarified any of the information that I have received from Connect Counselling & Therapy Society.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Counsellor Signature: _____ Date: _____

Check List for Counsellor

Take Home Package Reviewed with Client <input type="checkbox"/>	Client rights and responsibilities explained verbally <input type="checkbox"/>	Intake Completed <input type="checkbox"/>	Cancellation/No Show & Confidentiality Policy read and signed <input type="checkbox"/>	Date <input type="checkbox"/>
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