"THE TALK-IN CLINIC"
CLIENT INFORMATION SHEET

Welcome To Our Talk-In Clinic:
This clinic provides quick access to single-session counseling services for families with children from birth up to 18 years of age. It also is the main "gateway" into other services at Children's Mental Health. Please see our brochure for more details.

Please complete our Questionnaire(s). When you arrive, if the service area is busy, our Receptionist can give you an estimate of the waiting time. The counseling session will be about one hour long. The focus of the session is based on what you want from the meeting. Although many people find one session is enough, you may return to the Talk-In Clinic at any time even while you are on a wait list for services here.

Parent Involvement:
We believe that to help a child we must work in partnership with parents. This is true for youth, as well. However, youth 12 years of age or over have the legal right to private, confidential counseling although we usually encourage involvement of parents.

Client Files:
Each child/youth and family we see has his/her own file. The file may contain any of the following: information you have given us; written consents; correspondence received and sent for you; Talk-In questionnaires and Summary Report; Consent to Treatment; and the Confidentiality Statement. If you go on for further service, all information gathered at intake, assessment and/or treatment would then also become part of the file. You have the right to access your/your child's personal health information, which includes the client file.

Rights and Responsibilities:
We believe that as a client, you have certain rights and responsibilities. These include the right to confidentiality; to be treated with respect, honesty, and integrity; to receive competent and effective services; to withdraw from services at any time; to inform your counselor of any complaints about your/your child's services, to review your/your child's file with your/your child's counselor; to add information to the file that you may feel is important; and to request the correction of any factual errors in your/your child's file.

Treatment Planning:
All clients have the right to participate in assessment and treatment planning. At Children's Mental Health, we support you in voicing your treatment needs or desires and taking an active role in the creation of treatment goals. Treatment goals can be revised as needed.

Evaluation:
We also ask parents and youth who have used the service at our Talk-In Counseling Clinic to let us know what you thought of the service. Please complete our "Talk-In Clinic Client Evaluation" form at the end of your session and before you leave our office. It is very important that you give feedback that may assist us to modify, sustain or expand this service.

Confidentiality:
Services at Children's Mental Health are confidential, although there are exceptions when we must, by law, release information. The clinician who sees you will review these exceptions with you at the beginning of the session. Your written consent is required to release information to persons outside this agency. **The exception to this agreement is our legal requirement to report suspicions of child abuse, or a child in need of protection to Child Protection Services or if subpoenaed, to provide information through a Court Order. The final exception to this agreement (when we must release information without consent) is to inform someone in authority if a family member is in imminent danger of hurting him/herself or others.**

Cost:
Our services are funded by the Ministry of Child & Youth Service and the Ministry of Health. Dufferin Child and Family Services is a registered charity and we appreciate donations to help fund special activities such as camps and tutoring. Donations exceeding $10.00 to the Dufferin Children's Fund will receive a tax receipt.

Diversity:
Dufferin Child and Family Services recognizes, welcomes and accepts the diversity of our clients and their families with respect to race, national or ethnic ancestry, place of origin, colour, religion, citizenship, creed, gender, sexual orientation, age, marital status, family status, mental or physical disability, or language. If you require services in a language other than English, we will make every effort to accommodate you.

Problems/Complaint Process:
Do you have a complaint? If you do, we want to hear about it. Dufferin Child and Family Services has a process for you to raise concerns about any aspect of the services we provide. If you would like more information about our complaint process please ask your Clinician or pick up our pamphlet *"When We Disagree: A Guide to DCAFS Complaint Process"* from our office.

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CLIENT QUESTIONNAIRE – PARENT/GUARDIAN

Please fill in all fields

Parent/Guardian Name:_____ Today's Date: _____/_____/_____
YR MO DY

Child's Name (print below): Gender: _____

1)_____ DOB_____/_____/_____ Age___School:_____ GR___
YR MO DY

2)_____ DOB_____/_____/_____ Age___School:_____ GR___
YR MO DY

Address:_____ Phone: H_____ ☐ Message okay?
B_____ ☐ Message okay?
C_____ ☐ Message okay?

_____
town postal code

Family members: _____DOB: _____*(DD/MM/YY)*
(first & last names & _____DOB: _____*(DD/MM/YY)*
relationship to client) _____DOB: _____*(DD/MM/YY)*
_____DOB: _____*(DD/MM/YY)*
_____DOB: _____*(DD/MM/YY)*

Child's Legal Guardian:_____ Lives with:_____

Are you currently involved in any legal process regarding custody and access: ☐ Yes ☐ No
Is there a legal custody agreement? ☐Yes ☐No ☐N/A
If Yes: Custody Type:___ (A–Sole Custody Mother, B–Sole Custody Father, C–Joint Custody, D–Interim, E–Guardian, F-Other (explain))

If 'F' – Other, please explain:_____
_____

1. Has your child or family received services from our agency, Children's Mental Health Services, in the past or have you ever contacted our Crisis Services?
   ☐Yes, Date:_____ ☐No

2. **Who referred you to this clinic?** _____
   _____

3. Is your family receiving other services at this time: ☐Yes, please list below, ☐No
   _____
   _____

4. Are you, your child, or anyone with you, at risk of harm to self or to others?
   ☐Yes, Who:_____ ☐No

5. What concerns have brought you here today?_____

6. If **1** is the worst and **10** is the best, how are things in your life today?
   Worst -> 1 2 3 4 5 6 7 8 9 10 <-Best

7. How does this problem affect:
   a) you?_____
   b) your children?_____

8. What would be important for us to know about the background of this problem?_____

9. What would be most helpful to talk about in this meeting today?_____

10. How will you know when you have achieved the changes you desire?_____

11. Remember a problem that happened any time in your life that you resolved in such a way that left you feeling proud of yourself. What did you do that you felt proud of?_____

12. a) What would someone else come to admire and respect most about you if they had months or years to get to know you? It's OK to guess._____

    b) What would someone else come to admire and respect most about your child if they had months or years to get to know them? It's OK to guess._____

13. For us to be most helpful is there anything you feel is important for us to know about your culture, ethnicity, religion, language, sexual orientation, mental or physical health, or other?