|  |  |
| --- | --- |
| Date:       Click or tap to enter a date. *(mm-dd-yyyy)* | Parent/Caregiver/Guardian Name:       |

|  |  |
| --- | --- |
| [ ]  I am a caregiver looking for parenting support around my child/youth’s mental health struggles. | [ ]  I am the caregiver who booked the appointment and I will attend the session in support of my child/youth. |

|  |  |  |
| --- | --- | --- |
| Child-1, Full Name: |       | Gender: [ ]  M [ ]  F [ ]  Trans [ ]  Other |
| Date of Birth: |      Click or tap to enter a date. | *(mm-dd-yyyy)* |  Age:       |
| School: |       | Grade:       |

|  |  |  |
| --- | --- | --- |
| Child-2, Full Name: |  | *Gender: [ ]  M [ ]  F [ ]  Trans [ ]  Other* |
| Date of Birth: |       | *(mm-dd-yyyy)* |  Age:       |
| School: |       | Grade:       |

|  |  |
| --- | --- |
|  |  *Please X your preferred phone number* |
| Home Address: |       | [ ]  | Phone Home: |       | [ ]  |
| Town |       | [ ]  | Phone Work: |       | [ ]  |
| Postal Code |       | [ ]  | Phone Mobile: |       | [ ]  |
| Email: |       | [ ]  | Phone Other: |       | [ ]  |
|  |  *Please X if it is okay to leave a message* |

|  |  |  |
| --- | --- | --- |
| Family Members *(first and last name)* | Relationship to Client | Date of Birth *(mm-dd-yyyy)* |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|  |
| Client’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: [ ]  Sole Custody Mother [ ]  Sole Custody Father [ ]  Joint Custody [ ]  Interim [ ]  Guardian [ ]  OtherIf Other, please explain:       |

|  |  |
| --- | --- |
|  Who referred you to this agency? |       |

|  |  |
| --- | --- |
| 1. | Has your child or family received services from our agency in the past? |
|  | No [ ]  Yes [ ]  If yes, approximate date:       |
|  | If yes, which service(s) *check all that apply*:[ ]  Crisis [ ]  Child & Youth Mental Health [ ]  Child Protection [ ]  Infant & Child Development[ ]  iCAN [ ]  Service Coordination [ ]  Coordinated Service Planning [ ]  FASD [ ]  OAP [ ]  Groups (please list):       [ ]  Other:        |
|  | If yes, please provide relevant details:       |

|  |  |  |
| --- | --- | --- |
| 2.  | Is your family receiving other services at this time? | [ ]  No [ ]  Yes  |
|  | If yes, please list other services:       |

*To help us serve you better, please answer the following questions with as much detail as possible.
This will provide us with a better understanding of your needs as we prepare for your booked
 appointment and will help to ensure you get the most out of our time together.*

|  |  |
| --- | --- |
| 3.  | Are you, your child, or anyone with you, at risk of harm to self or to others? |
|  | [ ]  No [ ]  Yes, If yes, who is at risk?       |

|  |  |
| --- | --- |
| 4. | What concerns have brought you here today? |
|  |       |
|  |       |

|  |  |
| --- | --- |
| 5. | How are you feeling about things in your life today? |
|  |  Worst 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ]  Best |

|  |  |
| --- | --- |
| 6a. | How does this problem affect you? |
|  |       |
|  |       |
| 6b.  | How does this problem affect your children? |
|   |       |
|  |       |

|  |  |
| --- | --- |
| 7.  | What would be important for us to know about the background of this problem? |
|  |       |
|  |       |

|  |  |
| --- | --- |
| 8. | What would be most helpful to talk about in this meeting today? |
|  |       |
|  |       |

|  |  |
| --- | --- |
| 9. | How will you know when you have achieved the changes you desire? |
|  |       |
|  |       |

|  |  |
| --- | --- |
| 10. | Remember a problem that happened at any time in your life that you resolved in such a way that it you felt proud of yourself. What did you feel proud of or admire/resect about yourself in that moment? *(e.g., Confidence in managing a situation, or finding new ways to think/act/cope)* |
|  |       |
|  |       |

|  |  |
| --- | --- |
| 11a. | What would someone else admire and respect most about your child if they had time to get toknow them? |
|  |       |
|  |       |
| 11b. | What would someone else admire and respect most about you if they had time to get to know you? It is okay to guess. |
|  |       |
|  |       |

|  |  |
| --- | --- |
| 12. | 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 and/or gender identity/expression, mental/physical health or other? |
|  |       |
|  |  |

|  |  |
| --- | --- |
| 13. | Is there anything else you would like to tell us? |
|  |  |
|  |  |

***Thank you for coming to our Talk-In Clinic. Please feel free to come back again***