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

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| 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. |

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| 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: |

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|  | | *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* | | | |

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| Family Members *(first and last name)* | Relationship to Client | | Date of Birth *(mm-dd-yyyy)* |
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|  | | | |
| 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  Other  If Other, please explain: | | | |

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| Who referred you to this agency? |  |

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| 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.*

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| 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? |

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| --- | --- |
| 4. | What concerns have brought you here today? |
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| --- | --- |
| 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? |
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|  |  |
| 6b. | How does this problem affect your children? |
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| 7. | What would be important for us to know about the background of this problem? |
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| 8. | What would be most helpful to talk about in this meeting today? |
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| --- | --- |
| 9. | How will you know when you have achieved the changes you desire? |
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| --- | --- |
| 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)* |
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| 11a. | What would someone else admire and respect most about your child if they had time to get to know them? |
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| 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. |
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| 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? |
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| 13. | Is there anything else you would like to tell us? |
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***Thank you for coming to our Talk-In Clinic. Please feel free to come back again***