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REFERRAL/INTAKE FORM
MENTAL HEALTH PROGRAMS
YOUTH & ADULTS

INDIVIDUAL INTAKE FORM

To be completed by individuals ages 12+

First Name: _____ Last Name _____

Age: _____ Gender: _____

Birthday (mm/dd/yy) _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Marital Status: _____

Number of Children: _____ Ages of Children: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

PARENT(S)/GUARDIAN (FOR CLIENTS UNDER THE AGE OF 18 YEARS OLD)

Parent(s)/Guardian(s) Name: _____

If Guardian, please note relationship to child: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

EMPLOYMENT INFORMAITON:

On sick leave, as of this date: _____ Return to work date: _____

I was: Full time ☐ Part-time ☐ Position: _____

I am working full time at: _____ Position: _____

I am working part time at: _____ Position: _____

I am not working because: _____

ACADEMIC INFORMATION:

Not attending School: ☐ Highest level (grade) completed:

☐ Full time ☐ Part time Name of School: _____

School Program / Grades Information

Program: _____ Grade / Year:

Typical Grades _____

SOCIAL CULTURE

Preferred Language: _____

Which of the following would best describe your racial or ethnic group?

☐ Asian-East	☐ Asian – South	☐ Black-African
☐ Black- Caribbean	☐ Black-North American	☐ First Nations
☐ Inuit	☐ Métis	☐ Indigenous Aboriginal
☐ Indian Caribbean	☐ Latin American	☐ Middle Eastern
☐ White European	☐ White North American	☐ Mixed Heritage
☐ Do not know	☐ Prefer Not to Answer	☐ Other

REFERRAL/INTAKE FORM MENTAL HEALTH PROGRAMS YOUTH & ADULTS

Background(s): _____

Country of Birth: _____ Year of arrival into Canada: _____

Citizenship Status:

☐ Canadian citizen ☐ Sponsored refugee ☐ U.S Citizen

☐ Landed immigrant ☐ Refugee Claimant ☐ Other:

HOW YOU FOUND THIS PROGRAM:

Word of mouth ☐ I'm a former client ☐ Google / Search ☐

Referral (please name): _____

THE REASONS FOR YOUR VISIT:

How intense is your emotional distress?

(Mild) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 1 0 ☐ (Severe)

Please describe:

Overall, **how much do the problems affect your ability to perform** at work or school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ (Very disruptive)

Please describe

When did these problems start? What was going on in your life at that time?

BRIEF MEDICAL HISTORY

Please list any ***medical or "physical" or "mental"*** problems that you have been diagnosed with:

Please list any **medications you currently take**, and what you take them for:

Name of **Family doctor:** _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

General Results: _____

Please tell us about any other **mental health professionals you have consulted with in the past** (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

CURRENT HABITS

Please describe your ***current*** habits in each of the following areas:

Smoking: _____

Gambling: _____

Drinking: _____

Drug use: _____

Caffeine intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and Relaxation _____

What are your positive qualities and skills?

What do you like about yourself?

What qualities have helped you to succeed at overcoming difficulties in the past?

Please tell us about your plans for the future (career, personal, etc.)

How motivated do you feel to work on things in a group workshop?

What are your goals for this program?

What would you like to achieve by attending our workshops and peer support sessions?

What concerns do you have about attending our workshops or working on these problems?

Is there anything else that you would like to mention?

REFERRAL/INTAKE FORM MENTAL HEALTH PROGRAMS YOUTH & ADULTS

CONSENT TO PARTICIPATE IN GROUP MENTAL HEALTH PROGRAM

This consent form explains the nature of the services that you are about to receive. As consent is an ongoing process, any changes that may influence your consent will be discussed with you. Please note that our programs are not for severe cases of mental illness. If you are experiencing severe crisis, please contact your healthcare provider or call 911.

Nature of treatment:

(i) Open group workshops sessions,

(ii) Support: Depends on many factors, such as the nature of your difficulties and readiness for open discussion and change,

(iii) End of Program: Approximately 1-2 sessions at the end, involves developing a "toolbox" of strategies that may be used to help you maintain your mental health gains and reduce the likelihood of relapse and/or reoccurrence. Program effectiveness varies from person to person. Discussing, working with, and changing thoughts, feelings, and behaviours may be painful and challenging at times.

Approach: The workshop therapist will complete an intake assessment to understand how your current difficulties may have developed and are maintained within the various contexts of your life. The results of this assessment will be shared with you before start of workshops which are developed to help you reach your goals. Throughout the program you are invited to share any concerns or questions that you may have about the program/process. This helps us to help you better.

Fees and payment: Free

Confidentiality: Records may include items such as personal information, progress notes, and evaluations,and will be shredded 7 years after your file has been closed. No information about you can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include:

(1) when children are under 14 years of age, and their parents/legal guardians want access to the file,
(2) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group,
(3) suspected or known abuse or neglect of a child or older adult,
(4) unsafe operation of a motor vehicle,
(5) requests ordered by a court of law or
(6) access is required by other personnel (e.g., administrative staff) to carry out their professional duties.

Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: You may refuse any workshop suggestions offered to you, or you may discontinue the program at any time you wish. If you decide to discontinue for any reason, please notify your workshop supervisor or Counsellor so that your file can be closed and/or you can be referred to another resource. If you stop discontinue without an explanation, your file will automatically be closed after 30 days.

Consent to treatment: I have read and understood the above information, and any questions that I had have been answered. I agree with the above consent form, and freely consent to participate in the group mental health program.

Client Name	Signature	Date

Please compete if client is 13 years old or younger:

Parent / Guardian	Signature	Date
Parent / Guardian	Signature	Date

Client to Receive a Copy