



# Child Intake Form

Welcome to Shalom Counselling Centre of Central Alberta. Please complete the following Background Information Form. You are not required to answer all of the questions; however; answering all relevant questions allows us to be of more help. If you require more room for your information, please use additional pages. Your privacy is respected at Shalom; the information collected is treated with high professional standards of confidentiality and will only be shared with the Shalom team as required to serve you.

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ M/F

**Parent 1 -Primary Contact:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ M/F

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Parent 2:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ M/F

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Siblings:**

\_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

What parent does the child reside with? \_\_\_\_\_

**Primary Reason for Counselling**

- Individual/Personal Growth
- Family/Relational Reasons

**Best way to contact or leave message about appointments:**

Parent One – Primary Contact Information will be used

- Email
- Text
- Phone call

**Do you have insurance coverage?** Please indicate, as this impacts which counsellor you will be assigned to

- Yes
- No

How did you hear about Shalom Counselling Centre? \_\_\_\_\_

Has your child had previous or current counselling? When: \_\_\_\_\_ Where: \_\_\_\_\_

Was it helpful? Yes No If not, Why? \_\_\_\_\_

Has your child experienced any of the following?

Physical Sexual Emotional/Mental Economic Spiritual/Cultural Other

Is there a police file open? Yes No EPO/NCO Next Court Date: \_\_\_\_\_

Are there charges active or pending? Yes No Against Whom? \_\_\_\_\_

Do you have a case worker through Child and Family Services? \_\_\_\_\_

What other agencies are involved? \_\_\_\_\_

**Who has custody/decision making authority for the child?** \_\_\_\_\_ (Documentation Required)

Please note: We must have copies of the child custody arrangements before we can see your child

### **Sources of Family Income**

Employed Income Support (AE&I) Employment Insurance Pension Child Support

Assured Income for the Severely Disabled (AISH) Other: \_\_\_\_\_

### **Housing Situation of Family**

Own/Rent Family/Friends Shelter Hotel/Motel Transitional Housing Hospital  
Other \_\_\_\_\_

### **Marital Status of Parents** (select all that apply)

Single Dating Engaged Married Common Law Separated (from marriage or common-law)

### **Ethnic Culture**

*This question refers to the ethnic or cultural origins of a person's ancestry, who we identify as, or what environment we are from.*

North American Central America South America Caribbean Europe Africa

Middle East Asia Oceania Other: \_\_\_\_\_

## Religious Culture

*This question refers to how your child has been raised, based on the moral/social principles we use to govern our lives, and how we view the world.*

Christianity                      Native Spiritual                      East Indian: Sikhism, Buddhism, Hinduism  
Middle Eastern: Islam, Baha 'I, Judaism                      East Asian: Taoism, Shinto                      Spiritism/New Age  
Latin/Amerindian Traditional                      African Traditional                      Afro-Caribbean Traditional  
Secular/non-religious/non-spiritual                      Other: \_\_\_\_\_

## Medical & Psychological

Are there any know diagnoses? \_\_\_\_\_

Medications/vitamins/supplements: \_\_\_\_\_

## Primary Reason for Counselling

- Adjustment & Recovery
- Anger
- Boundaries/Self Care
- Bullying
- Communication
- Coping Skills
- Domestic Abuse
- Health & Wellness
- Healthy Eating Habits
- Lifestyle/Behavioral Changes
- Mental Health
- Navigating Grief & Loss
- Problem Solving
- Relationships
- Safety & well-being
- Self Acceptance
- Self Image or Identity
- Spiritual Health/Growth
- Stress Management
- Trauma
- Other: \_\_\_\_\_

**Has your child ever received a professional diagnosis and/or treatment for a mental health condition?**

- Yes
- No

**How would you score your current level of distress**

- 1 (Mild)
- 2
- 3
- 4
- 5 (Severe)

What do you think is the cause of this? \_\_\_\_\_

What do you hope will happen as a result of your child seeing a therapist?

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Action Taken: _____	Referred by (initial): _____	Additional connections made: _____
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