INTAKE FORM: CHILD AND / OR FAMILY THERAPY
(Please complete on behalf of your child)

Date of Referral *(yyyy-Mon-dd)*: _____

Name of person completing this form: _____

Address: _____ Postal Code: _____

Primary telephone number: _____ Secondary telephone number: _____

Email (*Please be aware that email might not be confidential)*: _____

Your relation to the child: _____

Name of other parent/guardian: _____

Address: _____ Postal Code: _____

Primary telephone number: _____ Secondary telephone number: _____

Email (*Please be aware that email might not be confidential)*: _____

Relationship status *(please indicate with an X)*:

( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed Other: _____

Child's name: _____

Gender: ( ) Female ( ) Male ( ) Other: _____ Birth date: *(yyyy-Mon-dd)*: _____ Age: _____

School: _____ Grade: _____

Family Doctor/Pediatrician/Psychiatrist: _____

Current Medications, if applicable: _____

Sibling(s) and ages *(indicate half- or step- if applicable)*:

Sibling #1: _____ Age: _____ Sibling #2: _____ Age: _____

Sibling #3: _____ Age: _____ Sibling #4: _____ Age: _____

Who lives with you in the home? _____

Emotional Wellness Therapy

Coping effectively with life and creating satisfying relationships

Please check any of the following reasons that led to your request for child and / or family therapy:

( ) ADHD	( ) Peer relationships	( ) Family conflict	( ) Parental separation/divorce
( ) Depression or anxiety	( ) Stress & coping skills	( ) Communication	( ) Remarriage decisions
( ) Identity and self-esteem	( ) Parent/child conflict	( ) Enhance relationship(s)	( ) Blended family & adjustment
( ) School-related concerns	( ) Behavioural issues	( ) Parenting practices	( ) Adjustment with grief/loss

Please speak to your primary reason(s) for your child and/or family's visit? How long has it been going on?

_____

_____

How is this issue currently affecting other aspects of your life (i.e., work, couple, family, parenting, school, etc.)?

_____

_____

What things have you tried to improve this issue? Did you experience any amount of success? Please explain.

_____

_____

Describe any significant stressors or life events that your child and/or family have experienced in the past 6 months.

_____

_____

Please list any previous counselling and/or services the child and/or family have received *(If yes, when, with whom, and outcome)*.

_____

_____

What do you consider to be your child's strengths? What do you appreciate most about your family?

_____

_____

What is your main goal for your child's and/or family therapy? What do you hope to accomplish through counselling? How will you know when your situation has improved?

_____

_____

Thank you for choosing Emotional Wellness Therapy!

Phone: (403) 710-3373 **E-mail: nelsoncd@shaw.ca** **Website: https://www.emotionalwellnesstherapy.ca**

#210 – 7720 Elbow Drive SW, Calgary, AB T2V 1K2