Delhi

Family Health Team

☐ *Referral for **Wendy*** ☐ *Referral for **Carey***

MENTAL HEALTH PATIENT QUESTIONNAIRE FOR CHILDREN & YOUTH

Please complete and return to reception. Once received, you will be contacted to schedule all 6-8 appointments.

Legal Name: _____

Date of Birth: _____ Age: ____ Family Doctor: _____

Do you have access to counselling through an Employee Assistance Program (EAP) funded by your employer?

☐ **No** ☐ **Not Sure** *(Note: We ask that people who have access to EAP use this service first. If you are not sure if you have EAP, please check with your Human Resources department or employee benefits package before going on to complete the rest of this form).*

☐ **Yes** *(Note: We ask that people who have access to EAP use this service first. If there is a reason that you are not able to do this, please note the reason below).*

_____

Best telephone number(s) to reach you: *(please specify contact name & if home, work, mobile number etc.)*

Tel: _____ Tel: _____

Can I leave a message on your voicemail identifying myself and leaving a call back number to reach me? **Home:** ☐ Yes ☐ No **Mobile:** ☐ Yes ☐ No

Can I leave a message with family identifying myself and leaving a call back number to reach me? **Home:** ☐ Yes ☐ No **Mobile:** ☐ Yes ☐ No

Mailing Address: _____

Do you have any special needs that we need to be aware of when scheduling your appointment?

☐ **No** ☐ **Yes** *(please specify)* _____

What kind of help would you like from the social worker? Please check all that apply:

☐ A one-time consultation appointment so the social worker can assess my situation and recommend resources and/or suggest strategies I can perform on my own

☐ Ongoing, short-term counselling *(approximately 6-8 sessions)*

☐ Referral to long-term counselling or more intensive support

☐ Information about community resources

☐ Other *(please specify)* _____

Please describe the history of your issues *(for example, how long have they existed? What is the severity of your symptoms?)*

_____

_____

_____

Have you needed to stop working because of your mental health? ☐ **No** ☐ **Yes**

Have you been to counselling in the past? ☐ **No** ☐ **Yes**

Are you on any anti-depressant and/or anti-anxiety medication or medication to help you sleep? If so, what is the name of the medication?

_____

_____

What are your goals related to counselling? _____

_____

_____

Do you have any other health conditions? _____

_____

_____

Do you have any other supports in place for the child/youth? Please check all that apply:

- ☐ Children's Aid Society
- ☐ Special Education Resource Teacher
- ☐ Behavioural Team
- ☐ Crisis Services
- ☐ Private Counsellor
- ☐ Other *(please specify)* _____

When working with separated families, consent from both parents is required for counselling services.

Are you currently separated/divorced? ☐ **No** ☐ **Yes**

If yes, is your ex-partner aware a referral has been made for counselling for your child?

☐ **No** ☐ **Yes**

Date: _____ **Signature:** _____