the shuswap family centre

SHUSWAP FAMILY CENTRE

INTAKE FORM

FOR OFFICE USE ONLY

DATE APPLICATION RECEIVED: _____

RECEIVED BY: _____

☐ CHILD & YOUTH MENTAL HEALTH

☐ SAIP

SEEKING SERVICES FOR: ☐ Self ☐ Child ☐ Other .....

CONTACT INFO		
Name:	Parent's name (if you are a minor):	
Phone:	Cell:	May we leave a message? ☐ Yes ☐ No
Email:	Best way to contact: ☐ email ☐ phone	
Address:		

GENERAL INFO		
How did you hear about our services?	Gender: Male ☐ Female ☐ Age:	Have you ever received counselling? ☐ Yes ☐ No
Are you currently receiving professional counseling or psychotherapy? ☐ Yes ☐ No	Other agencies involved:	
What is your main concern?		
Do you feel your spiritual or religious beliefs are relevant to your counselling needs? ☐ Yes ☐ No		

OTHER COMMENTS: