



SHUSWAP FAMILY RESOURCE & REFERRAL CENTRE
INTAKE FORM

FOR OFFICE USE ONLY

Date Application Received:

Received by:

- CYMHO/SAIP
- Community Counselling

SEEKING SERVICES FOR: Self Child Other

CONTACT INFO		
Name:	Parent's name (if you are a minor):	
Phone:	Cell:	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Best way to contact: <input type="checkbox"/> email <input type="checkbox"/> phone	
Address:		
GENERAL INFO		
How did you hear about our services?	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Have you ever received counselling? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Age:	
Are you currently receiving professional counseling or psychotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other agencies involved:	
What is your main concern?		
Do you feel your spiritual or religious beliefs are relevant to your counselling needs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
OTHER COMMENTS:		