Centre for Wellbeing in Education
EDT 408, 2500 University Drive NW
Calgary, AB, Canada T2N 1N4
https://werklund.ucalgary.ca/centre-for-wellbeing-in-education

COGNITIVE BEHAVIORAL THERAPY INTERVENTION FOR KIDS WITH ANXIETY (COPING CAT PROGRAM)

This information is collected under the authority of s.33 (c) of the *Freedom of Information and Protection of Privacy Act.* It is required to evaluate your application for the psychological intervention program at the centre. If you have any questions about the collection or use of this information, please contact the Administrative Assistant by email: werklundcentre@ucalgary.ca

Client's Last Name: _____ **Client's First Name:** _____

Date of Birth: _____ **Current Age:** _____
Month Day Year

Client/Guardian, please initial each item to signify your understanding of, and agreement with, the following statements:

I have read and understood the Conditions of Service as outlined on the Centre for Wellbeing in Education website including the following requirements:

___ I acknowledge that the Centre for Wellbeing in Education is a teaching clinic and that interventions will be completed by graduate student(s) under the supervision of qualified Faculty and staff within the Counselling Psychology program, University of Calgary.

___ All sessions are in-person and will be video recorded. The program will be conducted in rooms that allow for direct supervision via one-way mirrors and audio links to ensure you receive the highest quality care and support.

__ As a training facility that offers short-term interventions, the clinic is not able to respond to the needs of individuals with the following concerns:

- High suicidality or risk of violence
- Crisis situations requiring urgent care
- Eating disorders
- Severe substance use
- Active psychosis or mania
- Involvement in litigation

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___ This program is available for individuals 7-12 years of age and their parent/caregiver. In the case of minors, we require consent from parents or guardians with legal custody.

___ I hereby grant permission for staff from the Centre for Wellbeing in Education to read and screen the information provided by me as a basis for determining area of need and suitability for our students to provide service, and to contact prospective clients for a follow up interview.

_____ _____

Name of Consenting Client or Guardian Signature of Consenting Client/Guardian

_____

Today's Date:

HISTORY FORM

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YOUR PERSONAL INFORMATION
Address:
City/Town/Postal Code:
Phone number that our staff can reach you at:
Best time to call:
Email address:

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ADDITIONAL FAMILY INFORMATION		
Please list all members of the primary household, including adults and children:		
Name:	**Age**	**Relationship to You**

Family History: Tell us about your child

Parent/Guardian Information
With whom does this child live: ☐ Both parents ☐ Parent #1 ☐ Parent #2 ☐ Other (specify):
This child's parents are: ☐ Married ☐ Separated Year: _____ ☐ Living together ☐ Divorced Year: _____ ☐ Mother deceased ☐ Father deceased ☐ Other: _____
Is this child adopted or a foster child? Adopted ☐ Yes ☐ No | Fostered ☐ Yes ☐ No

If you checked YES to one of the above, when did this child become part of the family?

When a psychologist is providing professional services to a child who is a minor, the psychologist must obtain informed consent from the minor's parent/guardian. Generally, a psychologist is not required to obtain informed consent from both of the parents since either parent normally has the right to consent to services for the child. However, *if the parents are separated or divorced*, the psychologist must make appropriate inquiries to ensure that the adult requesting services is the child's legal parent/guardian. It is recommended by the College of Alberta Psychologists that psychologists obtain relevant court documentation prior to commencing services.

As a result of this requirement, the Clinic will request to view custody/access documentation pertaining to child clients. Also, should a custodial parent be unable/unwilling to participate in the service delivery process, they will be asked to provide a written (email) statement to that effect.

Has any family member had difficulty with any mental health issues (anxiety, depression, etc.)?

What is the primary language(s) spoken at home?

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Does your child have any health concerns to note (recurrent headaches, stomachaches, eating/sleeping difficulties, prescribed medications, diagnoses, etc.)? If yes, please explain.
PRIOR ASSESSMENTS AND INTERVENTIONS
Have you or your child participated in individual or group counselling previously? ☐ Yes ☐ No
If YES, please provide further details:
Has your family participated in family counselling? ☐ Yes ☐ No
If YES, please provide further details:
Does your child have any current diagnoses? ☐ Yes ☐No
If YES, please provide further details:

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Current Circumstances – why are you seeking service?
Please tell us about your current situation and what led you to seek services:
Client Goals and Hopes
Please tell us what you would like to achieve as a result of engaging in this program:
How did you hear about us?
☐Word of Mouth ☐Facebook ☐Twitter ☐ Returning Client ☐Referral ☐Other_____(*Please Specify)*

Download and Save this Application – and email it to werklundcentre@ucalgary.ca

What happens next?

Once your application has been reviewed, you will be contacted by a team member to determine eligibility for services. You can expect a call within approximately one to two weeks of submitting your application.