

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

INDIVIDUAL COUNSELLING SERVICES **CENTRE FOR WELLBEING IN EDUCATION**

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 Centre by email: werklundcentre@ucalgary.ca

Client's Last Name: Cl	lient's First Name:
Date of Birth: C	current Age:
Client/Guardian: please initial each item to sig statements:	gnify your understanding of, and agreement with, the following
I have read and understood the Conditions of website including the following requirements	Service as outlined on the Centre for Wellbeing in Education :
	ring in Education is a teaching clinic and that interventions will be upervision of qualified Faculty and staff within the Counselling
	I will be video recorded. Counselling will be conducted in rooms nirrors and audio links to ensure you receive the highest quality
As a training facility that offers short-tern individuals with the following concerns:	n interventions the clinic is not able to respond to the needs of
High suicidality or risk of violence	

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

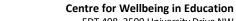


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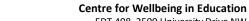
Services are available for individuals 14 y parents or guardians with legal custody.	ears or older. In the case of minors, we require consent from	
	he Centre for Wellbeing in Education to read and screen the rmining area of need and suitability for our students to provide a follow up interview.	
Name of Consenting Client or Guardian	Signature of Consenting Client or Guardian:	
Todays Date:		
	HISTORY FORM	
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YOUR PERSONAL INFORMATION		
Address:		
City/Town/Postal Code:		
Phone number:		
Best time to call:		
Email address:		





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ADDITIONAL FAMILY INFORMATION			
Please list all members of the primar	y household, including ac	lults and children:	
Name:	Age	Relationship to You	
Family History: Tell us about your chi	Idhood and upbringing:		
Has any family member had difficulty	with any mental health	issues (anxiety, depression, etc.)?	
What is the primary language(s) spok	en at home?		





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





Current Circumstances – why are you seeking service?
Please tell us about your current situation and what had led you to seek counseling supports:
What are your hope to achieve from counseling?
Please tell us what you would like to achieve as a result of engaging in this program:

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 the Academic Director of Counselling or the Administrative Coordinator to determine eligibility for services. You can expect a call within approximately one-week of submitting your application.