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	ient's First Name:
Date of Birth:	urrent Age:
Client/Guardian: please initial each item to sig statements:	nify 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
	ing in Education is a teaching clinic and that interventions will be spervision of qualified Faculty and staff within the Counselling
	will be video recorded. Counselling will be conducted in rooms irrors and audio links to ensure you receive the highest quality
As a training facility that offers short-term individuals with the following concerns:	n interventions the clinic is not able to respond to the needs of
High suicidality or risk of violence	

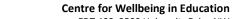
- Crisis situations requiring urgent care
- Eating disorders
- Severe substance use
- Active psychosis or mania
- Involvement in litigation



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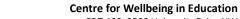
Services are available for individuals 14 yearents or guardians with legal custody.	ears or older. In the case of minors, we require consent from		
	ne Centre for Wellbeing in Education to read and screen the rmining area of need and suitability for our students to provide a follow up interview.		
Name of Consenting Client or Guardian	Signature of Consenting Client or Guardian:		
Today's Date			
- H	IISTORY 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 primary household, including adults and children:				
Name:	Age	Relationship to You		
Family History: Tell us about your c	hildhood and upbringin	g:		
Has any family member had difficul	ty with any mental hea	Ith issues (anxiety, depression, etc.)?		
What is the primary language(s) spoken at home?				

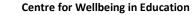




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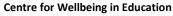
Do you have any health concerns to note (recurrent headaches, stomach aches, eating/sleeping difficulties, prescribed medications, diagnoses, etc.)? If yes, please explain.			
Parent/Guardian Information (Fill out if client is under 18 years of age)			
With whom does the client live: ☐ Both parents ☐ Parent #1 ☐ Parent #2 ☐ Other (specify):			
This client's parents are:			
Is this client adopted or a foster child? Adopted			
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.			





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Name of Parent #1/Guardian: Address: City/Town: Postal code: Day phone: Evening phone: Email address: Name of Parent #2/Guardian: Address: City/Town: Postal code: Day phone: Evening phone: Email address: PRIOR ASSESSMENTS AND INTERVENTIONS Have you participated in individual or group counselling previously? ☐ Yes □ No If YES, please provide further details: ☐ No Has your family participated in family counselling? ☐ Yes If YES, please provide further details: Do you have any current diagnoses? ☐ Yes ☐ No If YES, please specify:





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Current Circumstances – why are you seeking service?				
Please tell us about your cu	rrent situation and what ha	d led you to seek counseling supports:		
What are your hope to acl	nieve from counseling?			
Please tell us what you wou	ıld like to achieve as a resul	t of engaging in this program:		
How did you hear about u	s?			
☐Word of Mouth	□Facebook	□Twitter		
☐ Returning Client	□Referral			
□Other	(Please Specify)			
you like to receive information				

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.