CHILD DEVELOPMENT INSTITUTE

integra POWERED BY CHILD DEVELOPMENT INSTITUTE

INTAKE INFORMATION – COMPLETE & RETURN WITH ASSESSMENT REPORT

Part 1: Child/Youth Information

Name of Child/Youth: ____

M ___ F ___ Other___ **Date of Birth _____/_____/_____ (DD/MM/YY)**
Is this child adopted? ______ **Age at adoption: ______**

Please check which services you are currently interested in receiving from Integra (check all that apply):

☐ Family/Individual Counseling
☐ Parenting Group Program
☐ Integra Social ACES Group Program
☐ Towhee Summer Residential Program
☐ Integra Mindfulness Martial Arts Program/Integra Young Warriors Program

Part 2: Parent/Guardian Information

Name of parent/guardian 1 – PRIMARY CONTACT ____

M ___ F ___ Other _________

Year of Birth ___________

Relation to Child ________________________
(e.g. Parent/Grandparent/Aunt/Uncle)
Has legal access to child ☐ yes ☐no
Address ________________________________
____
City **Postal Code**
☐ Do not mail
Occupation ____________________________

Home Telephone ________________________
☐ Do not call ☐Do not leave message
Work Telephone ________________________
☐ Do not call ☐Do not leave message
Cell Telephone __________________________
**Please indicate your preferred phone #*
Email address ___________________________
☐ I agree to receive emails from Integra

Name of parent/guardian 2 – ALTERNATIVE CONTACT ____

M ___ F ___ Other _________

Year of Birth ___________

Relation to Child ________________________
(e.g. Parent/Grandparent/Aunt/Uncle)
has legal access to child ☐ yes ☐no
Address ________________________________
____
City **Postal Code**
☐ Do not mail
Occupation ____________________________

Home Telephone ________________________
☐ Do not call ☐Do not leave message
Work Telephone ________________________
☐ Do not call ☐Do not leave message
Cell Telephone __________________________
** Please indicate your preferred phone #*
Email address ___________________________
☐ I agree to receive emails from Integra

Note: email is not considered a secure form of communication and may be intercepted. We do not recommend emailing confidential information.

Primary Parent/Guardian Marital Status: ☐ Single ☐ Partner but not living together
☐ Common-law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Alternative Parent/Guardian Marital Status: ☐ Single ☐ Partner but not living together
☐ Common-law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Parent/Guardian Level of Education:

elementary	☐ some	☐ completed
high school	☐ some	☐ completed
college/trade school	☐ some	☐ completed
university	☐ some	☐ completed

Alternative Parent/Guardian Level of Education:

elementary	☐ some	☐ completed
high school	☐ some	☐ completed
college/trade school	☐ some	☐ completed
university	☐ some	☐ completed

Family Income Source ☐ Wages/salaries ☐ government assistance
☐ Employment insurance ☐ Other

Family Income: ☐ $0-$9999 ☐ $10,000 - $19,999 ☐ $20,000 - $29,999
☐ $30,000 – $39,999 ☐ $40,000 - $49,999 ☐ $50,000 - $59,999 ☐ >$60,000

Child lives with: (Please check all that apply)
☐ Parent 1 only ☐ Parent 2 only ☐ Both parents together ☐ Part time with each parent

Who is this child/adolescent's legal guardian?
☐ Primary Parent/Guardian only ☐ Alternative Parent/Guardian only ☐ Both Parents
☐ Other (Specify Below)

Name: ______________________________ **M ___ F ___ Other ____ Year of Birth: ______**

Relation to Child ______________________ **Occupation ____________________________**
(e.g., Grandparent/Aunt/Uncle)

Home Telephone______________________ **Address _______________________________**

Work Telephone ______________________ **_______________________________________**
City **Postal Code**

Cell Telephone ______________________
**Please indicate "Other's" preferred phone #*

Do you have legal authority to consent on your own to treatment for your child (i.e., that is without the consent of your child's other parent/guardian)? ☐Yes ☐No ☐I don't know
If no, both parents/guardians must sign all release forms.

Is your child's other parent aware of this referral? ☐Yes ☐No

Is the office of the child's lawyer involved? ☐Yes ☐No

Part 3: Additional Familial Information

i) Siblings and step-siblings

Name	Age	Lives With Whom	Relation to Child

Part 3: Additional Familial Information Continued

____________	______	____________	____________
Name	**Age**	**Lives With Whom**	**Relation to Child**

____________	______	____________	____________
Name	**Age**	**Lives With Whom**	**Relation to Child**

ii) Other relatives living with child (e.g., grandparents)

____________	____________
Name	**Relation to Child**

____________	____________
Name	**Relation to Child**

iii) Language (s) spoken at home ____

Do you need an interpreter? ☐Yes ☐No ☐I don't know

iv) Ethnicity of child: ____

Part 4:

1. How would you describe your child's learning disability? (i.e., areas of strength and challenge, how child learns best, etc)____

____

____

2. Please indicate your child's top 3 strengths.

☐ Accountable	☐ Empathetic	☐ Loving	☐ Self-aware
☐ Adaptable	☐ Encouraging	☐ Loyal	☐ Sense of humour
☐ Approachable	☐ Enthusiastic	☐ Motivating	☐ Sociable
☐ Athletic	☐ Fair	☐ Musical	☐ Supportive
☐ Brave	☐ Forgiving	☐ Optimistic	☐ Thoughtful
☐ Collaborative	☐ Friendly	☐ Persistent	☐ Well-regulated
☐ Creative	☐ Honest	☐ Playful	
☐ Curious	☐ Imaginative	☐ Reflective	
☐ Decisive	☐ Kind	☐ Resourceful	

Other strengths:____

3. Please indicate your top 3 concerns for your child:

☐ Aggressive Across Multiple Settings	☐ Break Rules	☐ Hearing Loss
☐ Aggressive Toward Others at Home	☐ Bullying Behaviour	☐ Hyperactivity/Impulsivity
☐ Aggressive Toward Others at School/Daycare	☐ Complex	☐ Language Delay
☐ Anxiety	☐ Cruelty to Animals	☐ Learning Disabilities
☐ Attention	☐ Depression (Withdrawn)	☐ Low Self-Esteem
☐ Autism Spectrum Disorder	☐ Developmental Delay	☐ Lying
☐ Behavioural	☐ Emotional	☐ Neglect
	☐ Emotional or Physical Abuse	☐ Oppositional Defiant
	☐ Emotional/Social Problems	☐ Parenting After Violence/Trauma
	☐ Fire Setting	☐ Parenting Issues/Skills

- ☐ Peer Problems
- ☐ Physical Needs
- ☐ Physically Attacks Others
- ☐ Police Contact
- ☐ Poor Social Skills
- ☐ Psychiatric
- ☐ Running Away
- ☐ Self-Harming
- ☐ Sensory Issues
- ☐ Separation/Loss Issues

- ☐ Sexual Behavior Inappropriate
- ☐ Sexually Abused
- ☐ Sibling Rivalry
- ☐ Significant Family Losses
- ☐ Sleep Disturbances
- ☐ Social
- ☐ Speech & Language
- ☐ Stealing
- ☐ Substance Abuse
- ☐ substance-Parent
- ☐ Suicidal Talk

- ☐ Suspensions from School
- ☐ Temper Tantrums
- ☐ Toilet Issues
- ☐ Trauma
- ☐ Truancy
- ☐ Vandalism (Destructive to Property)
- ☐ Visual Impairments
- ☐ Witness to Violence

4. What are your social concerns for your child? (i.e., how does your child get along with kids, adults)
____

____

____

____

5. What are your emotional concerns for your child? (i.e., intensity of emotions, how child copes with emotions, etc.) ____

____

____

____

6. What are your behavioural concerns for your child? ___________________________________

____

____

____

7. Who referred you to Integra? ____

8. Please list any agencies/professionals that you/your child are, or have been, involved with (i.e. social work, psychologist, psychiatrist, occupational therapist, speech and language pathologist, school counsellor, etc):

Name of Agency / Professional	Type of Service Received	Age/Date of Service
______________________________	______________________	________________
______________________________	______________________	________________
______________________________	______________________	________________

________________________________ ________________________ _________________

________________________________ ________________________ _________________

________________________________ ________________________ _________________

Part 5: School / Day Activity

Please check appropriate day activity of your child:

☐ **School: Grade _____** ☐ **Work** ☐ **No work or school**

☐ **Other (please specify) ____**

Name of School ___________________________________ School Board ______________________

If in Special Education, what type of class? ____

Name of Contact at child's school _______________________________

Address ____ Telephone Number _________________

Part 6: Health Information

Child's Health Card Number:

____ Expiry date:_________

This is a 10-digit number and 2-letter "version code"

Is your child taking any medication? ☐Yes ☐No **If yes, list below.**

Does your child have allergies? ☐Yes ☐No **If yes, please indicate details below.**

____

____

Please check any of the following which apply to your child:

☐ Seizures ☐ Physical Disability

☐ Medical Disorder ☐ Hospitalization/Operations

☐ Other (please specify below)

Further comments regarding the above ____

______________________________________ ___________________________________

Signature of Parent/Guardian **Date (DD/MM/YYYY)**