Welcome Letter

Hello, welcome to the Walk-in Counselling Clinic.
Please read the following service features. Once you see the Intake Worker, you will be able to ask any direct questions you have.

- The Walk-in Counselling Clinic provides Single Session counselling. A Single Session is about 1 hour long. Clients generally are seen in order of arrival, although, in some urgent situations, a client may be seen sooner. If we have filled up the available appointments for the day, we may have to ask you to return on the next clinic day.
- In the Single Session, you will be able to speak with a clinician who will work with you to create a plan and identify possible next steps to begin desired change.
- If you are attending one of the following locations: Bracebridge or Midland, then you will work with a clinician from one of our partnering agencies, (**Canadian Mental Health Association Simcoe, Catholic Family Services of Simcoe County, Centre de santé communautaire Chigamik Community Health Centre, Waypoint Outpatient Services, Wendat Community Programs, or Canadian Mental Health Association Muskoka-Parry Sound**). During your intake, you will be told which agency you will be assigned to. For all other clinic locations, services will be provided by staff from Catholic Family Services of Simcoe County.
- Please answer the questions in the Walk-In Package to the best of your ability. **If you require any help, please ask.**
- Once you have answered all the questions, please give the package to reception. An Intake Worker will meet with you shortly to discuss how we can assist you today and then set up an appointment with a clinician for your 1-hour Single Session.
- After your Single Session, we will ask you to complete a survey to let us know how you felt about the Single Session you attended. The anonymous information is used to report to our funders on how helpful the program has been to participants.
- At this time Catholic Family Services does not have childcare available. Due to potential distractibility, and the tendency for children to attune to the emotional atmosphere in the counselling session(s), parents/caregivers will need to arrange childcare **before** attending counselling. Please call our intake worker, before attending, if you need assistance in coming for counselling.
- Please Note: If you wish to return to the Walk-in Counselling Clinic, the same clinician may not always be available. **You can access a maximum of two (2) Single Sessions per month.**

Please note: We do not provide letters or reports for clients of the Walk-In Counselling Clinic.

Walk-In Survey (Pre-Service)

This survey will help us understand the impacts of our walk-in program. We will ask you the same questions again after service, along with some questions about your experience. This is an anonymous survey, so please do not put your name on the form.

Which clinic are you attending today?

(1)Alliston__ (2)Barrie__ (3)Bracebridge__ (4)Bradford__ (5)Collingwood__ (6)Midland__ (7)Orillia__ (8)Huntsville__

What concern brings you to our walk-in clinic today?

(1)Abuse/Violence__ (2)Addiction__ (3)Relationship__ (family, couple, parenting) (4)Personal Issues__ (like depression, grief, stress, anxiety) (5) Other__ (like job, legal, financial, housing, etc.)

Read each item below carefully. Using the scale shown, select the number that best describes ***how you think about yourself right now*.** Take a few moments to focus on yourself and what concerns you have in your life ***at this moment*.** Once you are ready, answer each item according to ***what is true for you right now***.

	strongly disagree	disagree	neutral	agree	strongly agree	
My current level of stress is manageable.	1	2	3	4	5	n/a
If I should find myself in a problem, I could think of many ways to get out of it.	1	2	3	4	5	n/a
Right now, I see myself as being successful in many areas of my life.	1	2	3	4	5	n/a
There are lots of ways around the problem that I am facing right now.	1	2	3	4	5	n/a
At this time, I am energetically pursuing my goals.	1	2	3	4	5	n/a
I can think of many ways to reach my current goals.	1	2	3	4	5	n/a
At this time, I am meeting the goals I have set for myself.	1	2	3	4	5	n/a
There are many places I can get support or resources to help me.	1	2	3	4	5	n/a

Where would you have gone for help if you had not come to the walk in clinic today?

(1)Family Doctor___ (2)Emergency___ (3)Medical Walk-in___ (4)Other Agency/Counsellor__ (CAS, New Path…)
(5)Other___ (6) No Where___

Where did you hear about our services?

(1) Website___ (2) Social Media____ (3) Community Event___ (4) Friend/Family____ (5) Other_____

Is there anything else you want to tell us right now?

OFFICE USE: Date Completed_____1st Initial: _____ 2nd Initial_____ DOB(DD/MM/YY):_____

Walk-In Counselling Clinic
Intake Screening Form

Welcome to the Walk-In Counselling Clinic! Please complete this form to the best of your ability. If you need any help please ask the Intake Worker.

Section 1

First name: _____ Last name: _____

Date of birth: _____(DD/MM/YYYY) Gender: _____

Email*: _____

*We value your privacy. We have a strict policy about keeping your personal information confidential. We would contact you by Email **only in the event** that any post-service survey related to your services with CFS is incomplete.

Home Phone: _____ Other Phone:_____

Can we leave a message at the number(s) listed? ☐ Yes ☐ No

Address:_____

City: _____ Postal Code:_____ Township:_____

Health Card #: _____Version Code:_____

Demographic Information:

Marital Status: ☐ Single ☐ Married /Common Law ☐ Separated /Divorced ☐ Widowed

Employment ☐ **C**urrently employed ☐ Currently between jobs ☐ Currently unable to work

Ethnicity: (please check if any apply) ☐ Francophone ☐ First Nations/Metis ☐ Other:_____

Languages spoken at home: ☐ English ☐ French ☐ Ojibway Other:_____

How did you find out about the Walk-In Clinic? Who referred you?_____

If your Partner/Spouse is attending with you today, please provide the following information:

First name: _____ Last name:_____

Date of birth: _____(MM/DD/YYYY)

If you have a child(children) or other dependant attending today, please provide their information.

First Name	*Last Name*	*DOB (MM/DD/YYYY)*	*Relationship*	*Office Use Active Client*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If you are requesting service for a child/children, are you the parent or legal guardian? ☐**Yes** ☐**No**

Name:_____ **Date:**_____

Section 2

1. Have you been to the Walk-In Counselling Clinic before? ☐ Yes ☐ No

2. Why have you come today?

_____

_____

3. If 10 is the best and 1 is the worst, how are things in your life today?

Worst 1 2 3 4 5 6 7 8 9 10 Best

4. What is the one problem that seems most important to work on now?

_____

_____

5. What would be the best thing that could happen in this meeting today?

_____

_____

6. Are you currently involved in any court or legal processes? ☐ Yes ☐ No

If yes, please specify the type of legal involvement:_____

7. Do you have a Family Physician? ☐ Yes ☐ No Name of physician: _____

8. Is your family currently involved with child protective services? ☐ Yes ☐ No
Name of worker: _____

9. Do you have concerns about Mental Health, yours or someone else's? ☐ Yes ☐ No ☐ Prefer not to answer

10. Do you have concerns about substance misuse , yours or someone else's? ☐ Yes ☐ No ☐ Prefer not to answer

Office Use Only

☐ **Case Accepted** ☐ **Case Not Accepted** ***(if not accepted list reason)***

Agency Assigned: ☐ CFSSC ☐ CMHA ☐ Chigamik ☐ Waypoint ☐ Wendat ☐ CMHA Muskoka

Intake Worker:_____ Clinician Assigned: _____

Appointment Date: _____ Appointment Time: _____

Conditions of Service – Walk-In Counselling Clinic

❒ I have read and understand the Welcome Letter.

❒ I have received the Catholic Family Services information handout. (***OPTIONAL:*** only if being seen by a CFSSC clinician)

❒ I understand that the Walk-In Single Session is meant to be a one-time meeting but I can make use of this service in the future in accordance to the description for usage in the Welcome Letter.

❒ I understand that the Walk-In Counselling Clinic, in some locations, is a collaborative initiative with various partners, with Catholic Family Services of Simcoe County being the lead agency and managing all clinics. The partnering agencies are: Canadian Mental Health Association Muskoka-Parry Sound; Canadian Mental Health Association – Simcoe County Branch; Catholic Family Services of Simcoe County; Centre de santé communautaire Chigamik Community Health Centre; Waypoint Outpatient Services; and Wendat Community Programs. As a result of this partnership, your information may be shared with other agencies based on the location in which you attend, which is discussed during your intake. As Catholic Family Services of Simcoe County provides intake services and management for all client information, it is responsible for securely storing your information. If you are seen by one of the other partnering agencies, your information will also be securely stored by that agency. In the situation where services are only provided by Catholic Family Services and partnering agencies are not involved, your information will be securely stored by Catholic Family Services and not by the partnering agencies.

> ❒ While I agree to the above, I do not want any information shared with the following partnering agency:_____

❒ I understand the limits of confidentiality as identified in the **Information about Services at Catholic Family Services of Simcoe County** leaflet.

❒ If I am involved with another service provider/organization (e.g. child protective services, an attorney...), then **I am willing** to sign a *third party release of confidential information* so that my clinician and the third party (e.g. child protective services) can exchange information about my case.

❒ If I am involved with another service provider/organization (e.g. child protective services, attorney...), then **I decline** to sign a *third party release of confidential information*.

❒ I understand that the Walk-In Counselling Clinic does not provide letters or reports for clients of the Walk-In Clinic.

❒ I have had the opportunity to ask questions, and those questions have been answered to my satisfaction.

I/We understand and consent to the above counselling conditions**.**

_____/___/___

Client Name Signature Date *(day/month/year)*

_____/___/___

Client Name Signature Date *(day/month/year)*

_____/___/___

Intake Worker's Name Signature Date *(day/month/year)*

Name:_____ Date:_____

Office Use Only

Presenting Issue: (PICK ONE)

☐ Threat to others/attempted suicide	☐ Serious mental illness	☐ Education
☐ Occupational/Employment	☐ Physical/Sexual Abuse	☐ Housing
☐ Financial Problems	☐ Challenges with relationships	☐ Legal
☐ Substance abuse/addictions	☐ Activity of Daily Living	☐ Other

Diagnostic Information- as reported by the client: (PICK ONE)

☐ Anxiety Disorder	☐ Mood Disorder	☐ Personality Disorder	☐ Sexual/Gender Identity Disorder
☐ Sleep Disorder	☐ Substance related	☐ Developmental Disability	☐ Eating disorder
☐ Psychotic Disorder	☐ Dissociative Disorder	☐ Disorder of childhood/adolescence	
☐ Stress/Situational Depression		☐ Unknown/Client Declined/None	

Community Referrals: (Please check all that apply)

The client was referred to the following service type:

☐ Primary Care Physician	☐ Crisis Line	☐ Hospital ER
☐ Counselling Program (FHT, CFS)	☐ Community Mental Health Service	☐ Addiction Services
☐ Housing Support	☐ Food Resource	☐ Social Assistance
☐ Child Welfare	☐ Credit Counselling	☐ Children's MH Services
☐ Parenting Support (OEYC, Triple P)	☐ Family Violence/Abuse	☐ Transitional Aged Youth Services

☐ Other _____

Intake Notes and Additional Information:

_____

_____

_____

_____

_____

_____