



Date:

Initial Contact Form

Instructions: Please complete all fields to the best of your ability. If you require assistance, please call or ask someone at reception.

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose	Address:	Telephone: Cell:	Can we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No E-mail:	What is your preferred language?
Are you of Aboriginal descent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Canadian Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Card Number and version code:	What is your Mental Health Diagnosis?	Addictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your source of Income?	Are you currently: <input type="checkbox"/> In school <input type="checkbox"/> Working <input type="checkbox"/> None
What is the highest level of education you have completed? <input type="checkbox"/> Elementary <input type="checkbox"/> Some High school <input type="checkbox"/> High School <input type="checkbox"/> Some college <input type="checkbox"/> College/University		Are you requesting a Psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever accessed Four County Crisis Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type of residence do you live in (e.g. own home, apartment, shelter, hospital)?		Who do you live with?
Referral Source: <input type="checkbox"/> Self or						
Name:						
Agency:						
Contact information:						
Please describe presenting concerns:						
Office Use Only						
Initial Contact Date:		Message Left: <input type="checkbox"/> Yes Worker:		Appointment booked: Date: Time:		
Remarks:						
Completed by:			Entered into C.R.M.S.: <input type="checkbox"/> Yes <input type="checkbox"/> No			