YSAC

Youth Services Virtual Intake Form

This form is to be completed in full when accessing Youth Services Virtual Programming at Leading Thunderbird Lodge (LTL).

Client Information: Virtual Program Start Date________________________

How did you hear of LTL: ____

Name:____

Date of Birth: _______________________________

Male: ☐ Female: ☐ Non-Binary:☐

Band Name and Treaty Number (**10 Digits**):

____

Client Address:

____

Client Email Address:____

Languages: Spoken English _____ Other: _________

Understood English _____ Other: _________

Referral Information

Social Services Involvement:

Agency Name: ____

Phone No.: ____________________________

Child Welfare Involvement:____

Client Status: Crown Ward ____, Society Ward ____, Voluntary Placement ____, Customary Care ____

VPA ____\ other: _____

Please make sure form is complete

Family History:

Biological Parents:

____

Guardian:

____

Address:

____

Phone No.:

____

Place of Employment:

____

Phone No.:

____

(Please list all who are considered siblings by the Client, including customary, step and foster siblings)

Name	Age	Health Status	Lives With

Extended Family:

Maternal: ____

Paternal: ____

Religious Beliefs: Traditional ☐ Roman Catholic ☐ Protestant ☐

Other: ____

Please make sure form is complete

Education:

Does Client go to school? Yes ☐ No ☐

Does Client like school? Yes ☐ No ☐

Still attending? Yes ☐ No ☐

Highest grade completed 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐

Name of school ____

Relationships:

Does Client live with: Mom ☐ Dad ☐ Alone ☐

Extended Family Members ☐ Siblings ☐ Friends ☐

Does Client get along with family members? Yes ☐ No ☐

Who does Client feel closest to?____________________________________

Does Client have any close friends? Yes ☐ No ☐

Does Client talk to any elders? Is he/she willing to listen? Yes ☐ No ☐

Does Client have a girlfriend or boyfriend? Yes ☐ No ☐

Is Client sexually active? Yes ☐ No ☐

Family Support: ____

Family Strengths: ____

Legal Problems:

Has Client ever been in trouble with the law? Yes ☐ No ☐

Has Client had any involvement with gangs? Yes ☐ No ☐

Was alcohol or any other substances, such as “sniff” or drugs involved during your Client’s legal problems? Yes ☐ No ☐

Is Client currently on probation or on a court order? Yes ☐ No ☐

Chemical Use History:

At what age did Client start **sniffing**? ____________________________

At what age did Client start using **alcohol**? _______________________

At what age did Client start **using other drugs**? __________________

Has your Client ever used any of the following?

Substance	Yes	No	How long? (months/years)
Gasoline			
Glue			
Cigarettes			
Spray Paint			
Rubber Cement			
Nail Polish Remover			
Hard Liquor			
Marijuana			
Fabric Protector			
Crack			
Beer			
Other			

Does anyone else in Client's family use solvents/substances? Yes ☐ No ☐

If so, who else? ____

What solvents/substances are mainly used? ________________________________

Does Client use solvents/substances with others or alone? _________________

Where does Client usually sniff or huff? _________________

Please make sure form is complete

Place	Yes	No	Last date used	Place	Yes	No	Last date used
At home				Abandoned Car /Truck			
A Friend's House				At a Party			
School				Outdoors			
Abandoned Building				Other			

Has Client ever lost friends because of sniffing or huffing? Yes ☐ No ☐

Has Client ever gotten into any physical fights when using? Yes ☐ No ☐

Has Client ever caused serious injury to others? Yes ☐ No ☐

Does Client have any medical, physical, psychological, emotional problems because of the use of solvents/substances? Yes ☐ No ☐

Does Client felt that they have control over their use of solvents/substances?
Yes ☐ No ☐

Has Client ever considered reducing or quitting? Yes ☐ No ☐

Has Client ever been in any previous treatment for their use of solvents/substances? Yes ☐ No ☐

Where ______________When______________________________________

How long did the Client stay in the program? _________________________

Psychological Functioning

Has your Client ever spoken or wrote about killing him/herself? Yes ☐ No ☐

Has your Client ever attempted to kill him/herself? Yes ☐ No ☐

How many times? __________Dates? __________________________________

How did he/she attempt to kill him/herself?_______________________________

Please make sure form is complete

Has Client frequently gone off on their own when depressed (unhappy)?

Yes ☐ No ☐

Is the Client sad/unhappy? Yes ☐ No ☐ None of the time ☐

Some of the time ☐ Most of the time ☐ All of the time ☐

Self-harming behaviors: Yes ☐ No ☐ Unknown ☐

Is there any known history of sexual abuse? Yes ☐ No ☐

Is there any known history of physical abuse? Yes ☐ No ☐

Is there any known history of emotional abuse? Yes ☐ No ☐

Trauma

Is there any history of family violence that this child may have been a witness to?
Yes ☐ No ☐

Is there any known history of other forms of traumatic experience?
(Including complex grief, bullying) Yes ☐ No ☐

Has he/she communicated with spirits that no one else can see or hear?
Yes ☐ No ☐
Has this happened? Never ☐ Sometimes ☐ Most of the Time ☐

Are there times when people are unable to communicate with the Client?
Not at all ☐ Sometimes ☐ Most of the time ☐ All of the time ☐

Has your Client ever had any psychological testing or counseling?
Yes ☐ No ☐

Outside Resources:

Are there any other agencies involved with your Client and
his/her family? Yes ☐ No ☐
If so, which ones and what services do they provide? (For example, NNADAP, CHR, CFS)

____

____

Please make sure form is complete

Family:

Family Activities/Practices: (What do you see as a family?)

____

Family Roles/Relationships: (How do they interact with each other?)

____

Status in the Community: (How is the family perceived in the community?)

____

What type of belief system is practiced? ________________________________

How does Client spend their leisure time? _______________________________

Who is the other support people involved with the family? (Example, elders, extended family, community groups, community workers, CHR, NNADAP, CWPW)

____

Is the Client/family aware of the effects of solvents/substances?

Client:	Yes ☐	No ☐
Family:	Yes ☐	No ☐
Community Worker:	Yes ☐	No ☐

Does the family believe the Client recognizes that they have a problem? What steps does the family want to take to address the problem?

____

Has anyone in the family received treatment for solvent/substance abuse?

____

Are the parent(s) supportive of their child receiving Virtual Treatment? (Refer to referral agent agreement and parental consent form) ____________________

Upon the child's completion of the Virtual Programming, what type of support system do you see as effective/useful to help maintain a clean lifestyle for self/child? ____

Are the extended family members supportive of the family seeking help and/or treatment for themselves or their child? ___________________________

Significant losses or areas that may be affecting the child related to unresolved grief

What are your expectations of this program?

_____________ ____

Please make sure form is complete

PARENTAL/GUARDIAN CONSENT TO VIRTUAL ONLINE TREATMENT

I/We, the parent(s)/ legal guardian(s) of ___________________________do hereby agree and consent to have the above named to participate in Virtual Online Programming treatment at Leading Thunderbird Lodge, Fort Qu'Appelle, Saskatchewan.

Virtual Intake date: ___________________________________

Programming End Date: ______________________________

(Please Print)

Parent/Guardian Name(s): ____

Parent/Guardian Signature(s): _______________________________________

Date: ____________________________

Witness: ____________________________

YOUTH CONSENT

I, _________________________________agree to participate weekly for 12 weeks at Leading Thunderbird Lodge's Treatment Center Virtual Online Programming, I understand that I will be expected to sign a "Treatment Agreement".

(Please Print)

Youth Name: __________________________________

Signature: __________________________________

Date: __________________________________

Witness: __________________________________

Please make sure form is complete

TREATMENT READINESS INVENTORY

INSTRUCTIONS: Read each statement then mark in the box whether you **AGREE** or **DISAGREE** with the statement as it applies to you personally at this time. Mark each statement truthfully. There is no right or wrong answer.

AGREE	DISAGREE	
☐	☐	1. I do not have a problem with drinking/drug use.
☐	☐	2. I know I drink/use too much.
☐	☐	3. I will quit drinking/using only when I am good and ready.
☐	☐	4. I do have a problem with drinking.
☐	☐	5. I must quit drinking/using once and for all
☐	☐	6. People talk about my drinking/using.
☐	☐	7. I have my drinking/using under control.
☐	☐	8. People can help with my drinking/using problems.
☐	☐	9. I do not want anyone telling me what to do about my drinking/using.
☐	☐	10. I can quit drinking/using whenever I want.
☐	☐	11. I need help now for my drinking/using problems.
☐	☐	12. My family worries about my drinking/using.
☐	☐	13. I do not care who knows I am getting help for my problems with drinking/using.
☐	☐	14. People have a good reason to talk about my drinking/using.
☐	☐	15. My drinking/using causes problems in my life.
☐	☐	16. No one is going to force me to quit drinking/using.
☐	☐	17. I need to talk honestly with other people about my drinking/using.
☐	☐	18. People have no reason to talk about my drinking/using.
☐	☐	19. I do not care who knows I am getting help for my problems with drinking/using.
☐	☐	20. There are times I had to cut down my drinking/using.
☐	☐	21 I cannot control my drinking/using any more.
☐	☐	22. There is no need for me to drink/use.
☐	☐	23. I am going to stop my drinking/using no matter what it takes.
☐	☐	24. I must do something about my drinking/using problems now, or they will only get worse.
☐	☐	25. What I do about my drinking is nobody’s business.

Please make sure form is complete

Virtual Treatment Agreement between Youth and Leading Thunderbird Lodge

All Clients are asked to follow the guidelines of the Virtual Programming:

ATTENDANCE:
Attendance and participation are the requirements for the Virtual Treatment. Module 1 is mandatory for participants to complete, after completion the Learner may choose to continue with the additional Modules and units in order to complete the programming.

It is a requirement to participate in a minimum of three counselling sessions the week following The Learning week. It is mandatory for Learners to complete the first Module, worksheets, and guided journal entries in order to receive their Certificate of Completion.

RESPECT
Learners are reminded to treat others with respect. This is an inclusive learning space!

CONFIDENTIALITY
Everything is kept confidential.

YOUTH ACTIVITY
Youth/Learners are encouraged to engage and participate in the program (worksheets, guided journals, counselling sessions, etc) and counselling sessions. Engagement and participation will ensure that the learner is getting the most out of the guided healing program.

A Learner may be removed from the program if they are not following the terms of the agreement and if they are not completing the required assignments and are not attending the counselling sessions.

YOUTH RIGHTS
Youth/Learners have the right to appeal any decisions made in regard to denial of further treatment services.

I, ____ sign this contract between myself and the staff at Leading Thunderbird Lodge. I realize that if I am not participating or completing the required Modules and Worksheets I will be discharged from the Virtual Program.

I acknowledge that I have discussed this with:

____

Staff member – name and title

on ____

Month/Day/Year

____

Name – Printed

Signature: ____

____

Date: Month/Day/Year

____

Witness – Family member/or Referral worker

LTL Staff Signature: ____

Date: _________________________