Creating Calm - A Group for Kids

Child's Name: ____________________________________ DOB: __________________
Child's School: ____________________________________ Grade: ________________
Parent/Guardian Name(s): ____
Address: ____
Home Phone: _______________________ Cell Phone: _________________________
Email Address: ____

How long has this child been experiencing anxiety? (days, weeks, months) ___________

What is the intensity of anxious symptoms (1 = very low and 5 = extremely high):

1 2 3 4 5

What, if any, stressful life events have led to the anxiety the child is experiencing?

____
____

Does the child enjoy school? ☐ YES ☐ NO

What is the child's preferred learning style?

☐ Visual ☐ Auditory ☐ Tactile or Kinesthetic

Does the child have any learning or behavioural challenges? ☐ YES ☐ NO
If yes, please describe ____
____

What anxious symptoms is the child experiencing? (please check all that apply)

- ❑ Rapid heartbeat
- ❑ Upset stomach
- ❑ Headaches
- ❑ Nervousness or being fidgety
- ❑ Sleep problems
- ❑ Avoidance of anxious topics
- ❑ Refusal to try new things
- ❑ Avoiding school
- ❑ Avoiding socializing with peers
- ❑ Fears and worried thoughts
- ❑ Cries easily
- ❑ Angry outbursts
- ❑ Separation anxiety from parents
- ❑ Constantly seeking reassurance
- ❑ Negative thinking patterns
- ❑ Other: ______________________

Has the child been assessed by a mental health specialist? ☐ YES ☐ NO
If yes, was there a diagnosis? Please describe: ___________________________________
____

What is the current stress level of the child's family (1 = not stressful at all and 5 = extremely stressful):

1 2 3 4 5

How does child function in a group? (1 = very comfortable and 5 = extremely uncomfortable)

1 2 3 4 5

Does the child have previous experiences in groups? Please describe: _______________
____
____

How willing is the child to get help for their anxiety? ______________________________
____
____

Parents are required to participate by attending the last 20 minutes of group each week and two parent-only evening sessions (6pm-7:30pm) to learn anxiety management strategies to practice at home with their child.

Is the parent willing and able to participate in the group program? ☐ YES ☐ NO
If not, why? ____

Thank you for your interest! You will be contacted by the Program Facilitator upon receipt of this referral. Parents and children are required to participate in an interview/orientation in order to ensure the program is a good fit for everyone. Due to Covid-19, groups will be small to ensure safety and social distancing.

If this referral is being made by a professional, is the parent aware of your application?
☐ YES ☐ NO

Signature of Parent: ____________________________ and/or

Signature of Referring Professional (if applicable): ________________________________

Please complete this form and send it to tammie.m@cvfsa.org or fax 250-338-2343.

For more information, please contact Leslie Fletcher at 250 338-7575 (extension 223).