



FAMILY INTAKE

Shareholder Information

OFFICE USE ONLY

Shareholder No.:

_____ | _____

Female Shareholder:

Family Name:		Name (First, Middle Initial):	
Workplace and Occupation:			Date of Birth:
Nation Affiliation: <input type="checkbox"/> Leni Lenape <input type="checkbox"/> Lakota <input type="checkbox"/> Ojibway <input type="checkbox"/> Cree <input type="checkbox"/> Oneida <input type="checkbox"/> Cayuga <input type="checkbox"/> Mohawk <input type="checkbox"/> Onondaga <input type="checkbox"/> Seneca <input type="checkbox"/> Metis <input type="checkbox"/> Odawa <input type="checkbox"/> Saulteaux <input type="checkbox"/> Pottawatomi <input type="checkbox"/> Other: _____		Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed - Looking <input type="checkbox"/> Unemployed - Not Looking <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	
Education Status: <input type="checkbox"/> Elementary (K-Gr. 8) <input type="checkbox"/> High School (Gr. 9-12) <input type="checkbox"/> College <input type="checkbox"/> University			
Are any of these issues affecting this person now:			
<input type="checkbox"/> Suicidal Behaviours <input type="checkbox"/> Family Loss (death, divorce, etc.) <input type="checkbox"/> Depression/Sadness <input type="checkbox"/> Family Violence <input type="checkbox"/> Legal Issues (someone arrested) <input type="checkbox"/> On Probation/Parole <input type="checkbox"/> Drug/Alcohol Abuse		<input type="checkbox"/> Spousal/Child Abuse <input type="checkbox"/> Anger/Temper Management <input type="checkbox"/> Gambling Addiction <input type="checkbox"/> Sex Addiction <input type="checkbox"/> Unresolved Childhood Issues <input type="checkbox"/> Lack of Cultural Knowledge <input type="checkbox"/> Grief Counselling	
		<input type="checkbox"/> Residential School Issues <input type="checkbox"/> Lack of Life Skills <input type="checkbox"/> Lack of Parenting Skills <input type="checkbox"/> Solvent Abuse <input type="checkbox"/> Workplace Stress <input type="checkbox"/> Relationship Issues <input type="checkbox"/> Lack of Communication Skills	

Male Shareholder:

Family Name:		Name (First, Middle Initial):	
Workplace and Occupation:			Date of Birth:
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Is a telephone interview recommended? <input type="checkbox"/> yes <input type="checkbox"/> no	Date of Telephone Interview:	Who interviewed the Family?	Estimated number of contacts with this family prior to intake? <input type="text"/>
Additional Comments and Outcomes:			