



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)

- | | |
|---|--|
| <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Avoiding socializing with peers |
| <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Fears and worried thoughts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Nervousness or being fidgety | <input type="checkbox"/> Angry outbursts |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Separation anxiety from parents |
| <input type="checkbox"/> Avoidance of anxious topics | <input type="checkbox"/> Constantly seeking reassurance |
| <input type="checkbox"/> Refusal to try new things | <input type="checkbox"/> Negative thinking patterns |
| <input type="checkbox"/> Avoiding school | <input type="checkbox"/> 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? _____

Additional Info: The next 10-week programs will take place at Comox Valley Family Services Association (3:30pm to 5:20pm):

Ages 7-9 starting September 16 // Ages 10-12 starting September 24

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).