

Social Enterprise Canada (“SEC”) Supervised Access Program

ADDITIONAL INTAKE INFORMATION
(for use by Administration)

Client’s Name: _____ **Date of Contact:** _____

Visiting Parent: _____ **Date of Contact:** _____

CHILDREN’S AID SOCIETY INVOLVEMENT

1. Has any Children’s Aid Society ever been involved with your immediate family?

Yes No

If yes, concerning whom?

What were the concerns of the Children’s Aid Society?

- Neglect*
- Physical Abuse*
- Sexual Abuse*
- Emotional/Psychological Abuse*
- Other, please specify:* _____

Did the Children’s Aid Society conduct an investigation? Yes No
If yes, what was the result of their involvement?

Is the Children’s Aid Society still involved with your family?

Yes No *If yes, in what capacity are they involved?*

- Working voluntarily with the family*
- Working with the family under a court or supervision order*
- Providing foster or residential care for the child(ren)*

Have any of the children been placed in the care of the Children's Aid Society?

Yes No *If yes, when _____ If yes, please specify:*
(DD/MM/YY)

- Voluntarily*
- Under a court order for Society Wardship*

VIOLENCE/ABUSE

2. Was there violence/abuse in your relationship with the other party?

Yes No

When did this occur? _____
(DD/MM/YY)

- While you were together*
- Since separation*
- Currently*

If yes, please indicate the type of violence.

- Physical*
- Emotional*
- Verbal*
- Sexual*
- Other, please specify*

Were you seriously hurt? Yes No

Was the other party seriously hurt? Yes No

Please describe:

Was medical attention required for your injuries?

Yes No

Were the police ever called about the other party's violence/abuse?

Yes No

Are you afraid of the other party?

Yes No

Have you ever been stalked/followed/threatened by the other party?

Yes No

Were the child(ren) ever exposed to the violence/abuse?

Yes No

Were the child(ren) in the home when the violence/abuse occurred?

Yes No

Was there violence/abuse against the children?

Yes No

If yes, by whom? _____

Please describe the violence against the children.

3. Have the police ever been involved with you or the other party?

Yes No

If yes, please indicate which police services

Municipal

OPP

RCMP

Please specify the location

4. A) Has a court ever made a restraining order against you or the other party?

Yes No

If yes, with respect to whom and when?

B) Has a Family Court been involved and, if so, are there any documents such as:

Affidavits, Motion records or responses (court proceedings)

Yes No

PLEASE PROVIDE COPIES OF ALL COURT DOCUMENTS

C) Do you have a signed Agreement regarding Supervised Access?

Yes No

PLEASE PROVIDE COPIES

5. **Have you or the other party ever signed a peace bond?**

Yes No

If yes, with respect to whom and when?

6. **Is there any information we should know about criminal charges concerning you or the other party(ies)?**

Yes No

If "yes" please explain:

7. **Is there any information about physical or mental health issues and/or drug/alcohol/substance abuse problems concerning yourself?**

Yes No

If yes, please answer the following:

Type of Problem:

- Mental health concerns/problems _____
- Alcohol Abuse _____
- Drug Abuse _____
- Physical Problems _____
- Other, please specify _____

Type of Treatment Sought:

- Physician
- Counsellor/Therapist/Psychiatrist/Psychologist
- Hospital
- Treatment Centre
- Follow-up Care (i.e. AA, NA, etc.)
- Medications, please specify _____

Name of Health Professional _____

Telephone Number _____

Address _____

8. **Is there any information about drug/alcohol/substance abuse problems concerning the custodial party?**

Yes No

If yes, please answer the following.

Type of Problem:

- Mental health concerns/problems _____
- Alcohol abuse _____
- Drug abuse _____
- Physical Problems _____
- Other, please specify _____

Type of Treatment Sought:

- Physician
- Counsellor/Therapist/Psychiatrist/Psychologist
- Treatment Centre
- Follow Up Care (i.e.. AA, NA, etc.)
- Other, please specify _____
- Medications, please specify _____

Name of Health Professional _____

Telephone Number(s) _____

Address _____

9. Is there any information about physical or mental health issues concerning the non-custodial party?

Yes No

If yes, please answer the following:

Type of Concern:

- Mental health concerns/problems _____
- Physical Problems _____
- Other, please specify _____

Type of Treatment Sought:

- Physician
- Counsellor/Therapist/Psychiatrist/Psychologist
- Hospital
- Other, please specify _____
- Medications, please specify _____

(non-custodial information con't)

Name of Health Professional _____
Telephone Number(s) _____
Address _____

10. Is there any information about drug/alcohol/substance abuse problems concerning the non-custodial party?

Yes No

If yes, please answer the following:

Type of Problem:

- Alcohol abuse _____
- Drug abuse _____
- Other, please specify _____

Type of Treatment Sought:

- Counsellor/Therapist/Psychiatrist/Psychologist
- Treatment Centre
- Follow Up Care (i.e.. AA, NA, etc.)
- Other, please specify _____
- Medications, please specify _____

Name of Health Professional _____
Telephone Number _____
Address _____

11. Is there any information about physical or mental health issues and/or behaviour concerns/special needs concerning the child/children?

Yes No

If yes, please answer the following:

(i) _____
(child's name)

(child/children's information con't)

Type of Problem:

- Mental health concerns/problems* _____
- Physical Problems* _____
- Behavioural Issues* _____
- Special Needs* _____
- Other, please specify* _____

Type of Treatment Sought:

- Physician*
- Counsellor/Therapist/Psychiatrist/Psychologist*
- Hospital*
- Other, please specify* _____
- Medications, please specify* _____

Name of Health Professional _____

Telephone Number _____

Address _____

(ii) _____

(child's name)

Type of Problem:

- Mental health concerns/problems* _____
- Physical Problems* _____
- Behavioural Issues* _____
- Special Needs* _____
- Other, please specify* _____

Type of Treatment Sought:

- Physician*
- Counsellor/Therapist/Psychiatrist/Psychologist*
- Hospital*
- Other, please specify* _____
- Medications, please specify* _____

Name of Health Professional _____

Telephone Number _____

Address _____