SECRET agent SOCIETY

SOLVING the MYSTERY of SOCIAL ENCOUNTERS®

Program Registration Form

Please complete all the questions on this form. This information will be kept strictly confidential.

Parent's name: ______________________________ **Date:** ______________

Address: ____

____ **Zip code:** ____________

Telephone contact numbers

Home: ____________________ **Mobile:** ________________________ **Work:**____________________

Email: ____

Please click to indicate your preferred weekly session day & time from the options shown below:

Child Group Meetings: Mon Wed Thu 3:30-5 pm 4-5:30 pm 4:30-6 pm

Alternate Option for Child Group Meetings: Saturday 10:30 am -12 noon

Parent Group Meetings: Mon Wed Thu 6:30-7:30 pm 7- 8 pm 7:30-8:30 pm

Meeting Preferred Format: In-person Telehealth Hybrid (i.e. combining in-person and telehealth)

Your child's name: ____

Child's date of birth: ____________________________ **Child's age** (*years*): ______________________

Child's gender: Female Male

Child's ethnicity:

Caucasian African American Latino Asian/Pacific Islander

Native American Other ____________________________

How are you related to the child?

Mother Father Guardian Other ____________________________

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What is your ethnicity?

Caucasian African American Latino Asian/Pacific Islander

Native American Other ____________________________

What is your occupation? ____

What is your highest level of education?

Up to high school diploma or equivalent

Technical/trade school or some college

College graduate or equivalent

Post graduate/Professional degree

Who does your child live with?

Both biological or early adoptive parents Single Parent Mother Father

Mother and step-father Father and step-mother

Equal time with separated/divorced parents

Other:______________________

What is the current marital status of biological parents?

Married How long:___________

Separated How long: ___________

Divorced How long: ___________

Other Described:___________

Apart from you, is there another caregiver who will be participating in this program?

Yes No

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If so, what is their name and relationship to the child?

Name: ____

Relationship to child: ____

What is their occupation? ____

What is their highest level of education?

Up to high school diploma or equivalent

Technical/trade school or some college

College graduate or equivalent

Post graduate/Professional degree

Child's school (if attending): ____

School telephone number: ____

Child's grade/year level at school: ____

Name of child's teacher: ____

Does your child receive any special assistance at school? Yes No

If so, please describe: ____

____

Is English your child's first language? Yes No

If not, please rate how well your child speaks and understands the English language:

Very poorly Poorly Reasonably well Well Very Well

Has your child been diagnosed with a mental health condition or psychological disorder, such as an Anxiety Disorder, Attention Deficit Hyperactivity Disorder (ADHD) or an Autism Spectrum Disorder?

Yes No

If so, which disorder(s)? ____

____

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For each condition, write down when the diagnosis was made and circle who made the diagnosis:

Condition	**When Diagnosis was Made**	**Who Made the Diagnosis**		
________________________	________________________	Psychiatrist	Pediatrician	Psychologist
		Other	______________	
________________________	________________________	Psychiatrist	Pediatrician	Psychologist
		Other	______________	
________________________	________________________	Psychiatrist	Pediatrician	Psychologist
		Other	______________	

Has your child ever been diagnosed with a learning disorder, language disorder or intellectual delay?

Yes No

If so, which conditions? ____

____

For each condition, write down when the diagnosis was made and circle who made the diagnosis:

Condition	**When Diagnosis was Made**	**Who Made the Diagnosis** (please circle)		
________________________	________________________	Psychiatrist	Pediatrician	Psychologist
		Other	______________	
________________________	________________________	Psychiatrist	Pediatrician	Psychologist
		Other	______________	
________________________	________________________	Psychiatrist	Pediatrician	Psychologist
		Other	______________	

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Has your child had an IQ test or learning ability test in the past 2 years?

Yes No

If so, please provide a copy of the results and/or report to the program facilitator.

Has your child ever been diagnosed with a medical condition or had surgery?

Yes No

If so, which condition(s) or what surgery? ____

____

For each condition, write down when the diagnosis was made and circle who made the diagnosis:

Condition	When Diagnosis was Made	Who Made the Diagnosis	
__________________________	_________________________	Pediatrician	Family Doctor
		Other	___________________
__________________________	_________________________	Pediatrician	Family Doctor
		Other	___________________
__________________________	_________________________	Pediatrician	Family Doctor
		Other	___________________

Does your child have any other health problems (e.g. allergies)? Yes No

If so, please describe: ____

____

____

Does your child take any medications? Yes No

If so, please list the medication names, dosages and what each medication is for (if known)

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Name	**Dosage**	**What is the medication for?**
______________________	________	______________________
______________________	________	______________________
______________________	________	______________________

Has your child received therapy or support in the past to cope with his/her emotions or to get along better with others? Yes No

If so, describe what this involved (e.g. individual anger management therapy, social skills group, etc).

____

____

____

For each therapy service or support listed, note when and how long the service was received for, and who provided it (e.g. Individual therapy for anxiety, September-November, 2013; approximately 10 weeks, psychologist at Psychological Solutions clinic).

Service/Support	**Date Received (Year and months)**	**Duration**	**Provider**
______________	___________	________	___________
______________	___________	________	___________
______________	___________	________	___________
______________	___________	________	___________
______________	___________	________	___________

Is your child receiving therapy or support at the moment to cope with his/her emotions or to get along better with others? Yes No

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If so, describe what this involves e.g. individual anger management therapy, social skills group, etc).

___

___

___

Please provide contact details for any professionals who your child is currently seeing for help with mental health conditions, developmental delays and/or learning difficulties:

___

___

___

What hobbies or interests does your child have?___

___

Please list below the three major difficulties that your child is experiencing at the moment (*e.g. bullying at school, problems making friends, poor anger management, unwillingness to try new activities, difficulties adjusting to changes in routine, etc*).

1. ___
2. ___
3. ___

Please describe the changes that occur in your child's behavior when they feel anxious (*e.g. changes in facial expression, body posture, voice tone, complaints of stomach aches, muscle tension, etc*).

___

___

___

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Please describe the changes that occur in your child's behavior when they FIRST start to become angry or frustrated (*e.g. changes in facial expressions, body posture, voice tone, muscle tension etc*).

____

____

____

Describe up to five common situations where your child feels anxious, worried or scared. Rate how anxious you think your child feels in each situation on a scale from 1 (a little anxious) to 10 (extremely anxious).

Situation:	Anxiety Rating (1-10):
1.	
2.	
3.	
4.	
5.	

Describe up to five common situations where your child feels angry or frustrated. Rate how angry you think your child feels in each situation on a scale from 1 (a little angry) to 10 (extremely angry).

Situation:	Anger Rating (1-10):
1.	
2.	
3.	
4.	
5.	

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Please rate how confident you are in your ability to support your child's social and emotional development.

0	1	2	3	4	5
Not at all confident	*Slightly confident*		*Moderately confident*		*Very confident*

Does your child have access to a device larger than a phone at home? Yes No

Does your child have access to the internet at home? Yes No

Please provide any additional information that you think is important for us to know.

____

____

____

Sometimes we lose contact with families who participate in our programs. To help us stay in touch with you, please provide the details of two relatives or friends who you would be willing for us to phone to obtain your contact details if necessary.

Name(s): Phone number(s):

__________________________ ______________

__________________________ ______________

* * * * * * * * * * * * *

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Parental Consent to Participate in Program

I give consent for myself and my son/daughter to take part in this program on the understanding that:

1. I am aware of the aims and structure of the program.
2. I have had the opportunity to ask any questions arising from the information provided and these questions have been answered to my satisfaction.
3. The program facilitator may contact my child's teacher and other supporting professionals to find out more about my child's social-emotional functioning and behavior and to brief these people on the Secret Agent Society Small Group Program.
4. If needed, the program facilitator may wish to do an observation of my child at their school.
5. I am aware that some SAS group meetings (child and parent) will be filmed for the purposes of peer supervision and support sessions.
6. The information that I provide will be kept confidential.

Child's Name: ____

Parent/Guardian's name: ____

Parent/Guardian's signature: ____

Date:____

Thank you for completing this registration form. Please return this form to your program facilitator in order to schedule the program intake interview.

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