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Please fill out form completely
-Write N/A if unknown
-Submit all required pages
-Return completed form to office/confidential email

***SEM-Care WellnessSM* School-Based Program**

ENROLLMENT/REFERRAL FORM

Your student's school has teamed up with Divine Youth Wellness Centre, LLC (DYWC) to offer **play-based therapy sessions** and **social-emotional learning small groups** at schools through a new initiative: *Social-Emotional Care & WellnessSM* (SEM-Care Wellness). A skilled therapist from DYWC will be there to help students aged 5-16 manage any family or school-related adjustments they may be facing. Students enrolled in our play-based therapy program will receive **eight weekly sessions for free**.

Student's Name: _____ DOB: ____/____/____ Age: ____

Address: _____

Parent/Guardian Name: _____ Phone: (____) _____

School Name and Address: _____

Referred by (name): _____ Phone: (____) _____

Presenting Problems: What is the Student dealing with currently?

- | | | |
|--|--|--|
| <input type="checkbox"/> Dramatic change in behavior | <input type="checkbox"/> Sadness | <input type="checkbox"/> Self-image/confidence |
| <input type="checkbox"/> Worries/Nervous/Anxious | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Anger/Conflict |
| <input type="checkbox"/> Swearing | <input type="checkbox"/> Aggression/Fighting | <input type="checkbox"/> Self-Harm |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Grief/Bereavement | <input type="checkbox"/> Lying/Dishonesty |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Disrespect | <input type="checkbox"/> Disruptive |
| <input type="checkbox"/> Defiance/Non-Compliance | <input type="checkbox"/> Over/Hyperactive | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Chews (paper/clothes/hair) | <input type="checkbox"/> Property Destruction | <input type="checkbox"/> Sexual Acting Out |
| <input type="checkbox"/> Low/Poor Social Skills | <input type="checkbox"/> Absences/Tardiness | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Poor Academics | <input type="checkbox"/> Low/No Motivation |
| <input type="checkbox"/> Inattentive/Low Focus | <input type="checkbox"/> Poor work habits/organization | <input type="checkbox"/> Dropout risk (H.S.) |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Neglect | <input type="checkbox"/> Abandonment |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Emotional/Mental Abuse | <input type="checkbox"/> Family Concerns |
| <input type="checkbox"/> Other (or additional details for above issue(s)): _____ | | |

Student's current education level:

- | | |
|---|---|
| <input type="checkbox"/> Elementary (Specify Grade): _____ | <input type="checkbox"/> Middle School (Specify Grade): _____ |
| <input type="checkbox"/> High School (Specify Grade): _____ | <input type="checkbox"/> Other (Specify): _____ |

Student's race/ethnicity:

- | | |
|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Bi-Racial/Multiracial |
| <input type="checkbox"/> Native American or American Indian | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Other (Specify): _____ |

Student's gender identity:

- | | |
|---|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| <input type="checkbox"/> Trans Female (MTF or male to female) | <input type="checkbox"/> Trans Male (FTM or female to male) |
| <input type="checkbox"/> Student Doesn't Know | <input type="checkbox"/> Other: _____ |

Primary Caregiver Age:

- | | | | | | | |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|
| <input type="checkbox"/> 15-19 | <input type="checkbox"/> 20-34 | <input type="checkbox"/> 35-54 | <input type="checkbox"/> 55-64 | <input type="checkbox"/> 65-74 | <input type="checkbox"/> 75-84 | <input type="checkbox"/> 85+ |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|

Primary Caregiver Race/Ethnicity:

- | | |
|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Bi-Racial/Multiracial |
| <input type="checkbox"/> Native American or American Indian | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Other (Specify): _____ |

Caregiver #2 Age:

- | | | | | | | |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|
| <input type="checkbox"/> 15-19 | <input type="checkbox"/> 20-34 | <input type="checkbox"/> 35-54 | <input type="checkbox"/> 55-64 | <input type="checkbox"/> 65-74 | <input type="checkbox"/> 75-84 | <input type="checkbox"/> 85+ |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|------------------------------|

Caregiver #2 Race/Ethnicity:

- | | |
|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Bi-Racial/Multiracial |
| <input type="checkbox"/> Native American or American Indian | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Other (Specify): _____ |

Referral for Membership Department: (Please check all that apply):

- ☐ SEM-Care Wellness: Brief Play-Based Solution-Focused Therapy for Individuals
- ☐ SEM-Care Wellness: Social-Emotional Learning Small Groups

-----Office Use Only-----

Date received: _____

Date of Confirmation with Referrer: _____

(If Applicable) Inappropriate Referral, Referred to: _____