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 **INSTANT CHANGE**

**Address:**

**4690 Millennium Dr, 3rd Floor Belcamp, 21017 Email:** **instantchange@gmail.com**

**Tel: (240)263-0848 Website: https://www.instant-change.net**

**Application:**

**Mental Health Support Form**

**Personal Information:**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Support Needed:**

1. What type of mental health support are you seeking? (Check all that apply)
	* Counseling/Therapy
	* Crisis Support
	* Stress Management
	* Depression/Anxiety Support
	* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you received mental health support before?
	* Yes
	* No
3. If yes, please describe past support: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you have any current mental health concerns? (Briefly describe)
5. Are you experiencing any of the following? (Check all that apply)
	* Difficulty sleeping
	* Feeling overwhelmed
	* Changes in appetite
	* Suicidal thoughts
	* Difficulty concentrating
	* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Support Method:**

* In-Person
* Phone Call
* Video Call
* Email Support

**Additional Comments:**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_