**A family with a child and a box

AI-generated content may be incorrect.**

**INSTANT CHANGE**

**Address:**

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**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_