Simcoe Muskoka Family Connexions | Connexions Familiales de Simcoe Muskoka

COUNSELING WALK-IN CLINIC

CLIENT QUESTIONNAIRE - COLLATERAL

Name: _____ Date: _____/_____/_____
MO DY YR

Your relationship to the child: _____

Your Agency/Service Affiliation: _____

Your Address: _____ Phone (Business):_____

_____
city postal code

Child's/Youth's name:

_____ DOB____/____/____ Age ___ School: _____ GR ___
MO DY YR

Address: _____ Phone: H _____
_____ B_____
city postal code

Family members:

Name: _____ Relationship: _____ DOB ____/____/____
MO DY YR

Name: _____ Relationship: _____ DOB ____/____/____
MO DY YR

Name: _____ Relationship: _____ DOB ____/____/____
MO DY YR

Name: _____ Relationship: _____ DOB ____/____/____
MO DY YR

Name: _____ Relationship: _____ DOB ____/____/____
MO DY YR

Child's Legal Guardian: _____Lives with: _____

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1. Has this family/child received Children's Mental Health services from our agency in the past?

   ❑ YES Date: _____ ❑ NO

2. List any other services currently involved: _____

_____

_____

3. What concerns do you have about this family/child?

_____

_____

_____

Please turn page over …

4. How would you rate your concerns for this family/child today (Please circle)?
   Mild Moderate High Very High Extreme

5. What is the one problem that seems important to work on now?

6. What would be important for us to know about the background of this problem?

7. What is this family's/child's strengths?

8. What would you like to see accomplished in this meeting today?

9. In what ways do you currently provide support to this child/family?

10. In what ways could you offer further or different support?