Simcoe Muskoka Family Connexions | Connexions Familiales de Simcoe Muskoka

COUNSELING WALK-IN CLINIC

CLIENT QUESTIONNAIRE – PARENT/GUARDIAN

Parent/Guardian Name(s): ____ **Date:** _____/_____/_____
MO DY YR

Child/Youth's Name:

_______________________________ **DOB**____/____/____ **Age** _____ **School**: ____________________ **GR** _____
MO DY YR

Address: ____ **Phone:** Home ____________________ ❑ Message okay?
Bus. ____________________ ❑ Message okay?
____ Cell ____________________ ❑ Message okay?
City/Town postal code

Family Members: *(and relationship to child/youth)*

Do they live with you?

Name: ____________________________ Relationship: __________________ DOB ____/____/____ ☐ Yes ☐ No
MO DY YR
Name: ____________________________ Relationship: __________________ DOB ____/____/____ ☐ Yes ☐ No
MO DY YR
Name: ____________________________ Relationship: __________________ DOB ____/____/____ ☐ Yes ☐ No
MO DY YR
Name: ____________________________ Relationship: __________________ DOB ____/____/____ ☐ Yes ☐ No
MO DY YR
Name: ____________________________ Relationship: __________________ DOB ____/____/____ ☐ Yes ☐ No
MO DY YR

Family Doctor: ________________________________

Child's Legal Guardian: ______________________________ **Lives with:** ________________________________

Are you currently involved in any legal process regarding custody and access? ❑ YES ❑ NO
Is there a legal custody agreement? ❑ YES ❑ NO

Custody Type___________ (A-Sole Custody Mother, B-Sole Custody Father, C-Joint Custody, D-Interim, E-Other (explain))

If E-Other, Please explain: ____

If you do not have full custody, please include the contact information for the other custodial parent below:

Name: ____________________________ Relationship: _____________________ Home Ph: ____________________

Address: ______________________________ ______________________________ Cell: ____________________
City/Town Postal Code

*****Does the other custodial parent know you are attending the Walk-In Clinic and do you have their approval?**

❑ YES ❑ NO If no, we cannot continue with services.

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

   ❑ YES Approximate Date: ____________ ❑ NO

2. Who referred you to this clinic? ____

3. List any other services involved: ____

4. Are you, your child, or anyone with you, at risk of harm to self or to others?

   ❑ YES Who: ________________________________ ❑ NO

Please turn page over… ➡

1. What concerns have brought you here today? ______________________________

____

____

____

2. If 1 is the worst and 10 is the best, how are things in your life today?
☹ Worst 1 2 3 4 5 6 7 8 9 10 Best ☺

3. How does this problem affect:
a.) you? ______________________________
b.) your children? ______________________________

____

____

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

____

____

____

5. What would be most helpful to talk about in this meeting today?

____

____

____

6. How will you know when this problem is starting to get better?

____

____

____

8. a) What would someone else come to admire and respect most about you if they had months or years to get to know you? It's OK to guess.

____

____

____

8. b) What would someone else come to admire and respect most about your child if they had months or years to get to know them? It's OK to guess.

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9. For us to be most helpful is there anything you feel is important for us to know about your culture, ethnicity, religion, language, sexual orientation, mental or physical health, or other?

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