Simcoe Muskoka **Family Connexions** | **Connexions Familiales** de Simcoe Muskoka

COUNSELING WALK-IN CLINIC

CLIENT QUESTIONNAIRE – CHILD/YOUTH

Name: ______________________________ Age: __________ Date of Birth: _____/_____/_____
MO DY YR

Address: ____________________________________ Phone#: _________________________

____________________________________ Today's Date: ________/______/________
city postal code MO DY YR

Parent/Guardian Name(s): __________________________________ Phone#: _________________

Family Members: ____

School: ____ Grade: ________________

Family Doctor: ____

1. Have you received Children's Mental Health services from our agency in the past?
   ❑ YES Date: ____________________ ❑ NO

2. Why have you come today?

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3. 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 ☺

4. What would be the best thing that could happen in this meeting today?

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

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6. What is it like when this problem is around?

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7. Are you currently at any risk of harm to yourself or to others? ❑ YES ❑ NO

8. What would someone else like and respect most about you if they had a lot of time to get to know you? 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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