

"THE TALK-IN CLINIC"

CLIENT QUESTIONNAIRE – CHILD/YOUTH

Please fill in all fields

Name: _____ Age: _____ Date of Birth: ____/____/____
YR MO DY

Address: _____ Phone #: _____

town postal code

Parent/Guardian Name(s): _____ Phone #: _____
 Family Members (first & last names): _____

School: _____ Grade: _____

1. Have you received services from our agency (ie. Children's Mental Health Services in the past or have you ever contacted our Crisis Services? Yes, Date: _____ No

2. Why have you come today? _____

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

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

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

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? _____

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?

