

"THE TALK-IN CLINIC"

CLIENT QUESTIONNAIRE – COLLATERAL

Please fill in all fields

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

Your relationship to the child/youth: _____

Your Agency/Service Affiliation: _____

Your Address: _____ Phone #: _____
town postal code

Child/Youth's Name:

1) _____ DOB ____/____/____ Age: _____ School: _____ GR _____
YR MO DY

2) _____ DOB ____/____/____ Age: _____ School: _____ GR _____
YR MO DY

Address: _____ Phone: H _____
town postal code Phone: B _____

Family Members: _____ DOB: _____
 _____ DOB: _____
 _____ DOB: _____
 _____ DOB: _____

Child's Legal Guardian: _____ Lives with: _____

1. Has this family/child/youth received services from our agency (ie. Children's Mental Health Services) in the past? YES Date _____ NO
2. List any other services involved: _____

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

4. How would you rate your concerns for this family/child/youth?
 Worst 1 2 3 4 5 6 7 8 9 10 Best

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/youth'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 family/child/youth? _____

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