"THE TALK-IN CLINIC"

CLIENT QUESTIONNAIRE – CHILD/YOUTH

Please fill in all fields Todays Date: _____ *(mm/dd/yy)*

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

Gender:_____(Male/Female/Other)

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

Parent/Guardian Name(s):_____
Family Members *(first & last names, relationship to client)*:_____

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

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?