|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date: Click or tap to enter a date.  *(mm-dd-yyyy)* | | | Child/Youth’s Full Name: | | |
| Date of Birth: | | Click or tap to enter a date.  *(mm-dd-yyyy)* | | Age: | Gender:  M  F  Trans  Other |
| School: |  | | | | Grade: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | ***Please X your preferred phone number*** | | | |
| Home Address: |  |  | Phone Home: |  |  |
| Town |  |  | Phone Work: |  |  |
| Postal Code |  |  | Phone Mobile: |  |  |
| Email: |  |  | Phone Other: |  |  |
|  | | ***Please X if it is okay to leave a message*** | | | |

|  |  |  |
| --- | --- | --- |
| Family Member *(first & last name)* | Relationship to Child/Youth | Date of Birth *(mm-dd-yyyy)* |
|  |  | Click or tap to enter a date. |
|  |  | Click or tap to enter a date. |
|  |  | Click or tap to enter a date. |
|  |  | Click or tap to enter a date. |
|  |  | Click or tap to enter a date. |

|  |  |  |
| --- | --- | --- |
| 1. | Have you received services from our agency in the past? | |
|  | No  Yes  If yes, approximate date: | Click or tap to enter a date. |
|  | If yes, which service(s) *check all that apply*:  Crisis  Child & Youth Mental Health  Child Protection  Infant & Child Development  iCAN  Service Coordination  Coordinated Service Planning  FASD  OAP  Groups (please list):        Other: | |
|  | If yes, please provide any other relevant details: | |

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| --- | --- |
| 2: | Why have you come to Talk-In today? |
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| --- | --- |
| Date: Click or tap to enter a date.  *(mm-dd-yyyy)* | Child/Youth’s Full Name: |

|  |  |
| --- | --- |
| 3: | How are you feeling about 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? |
|  |  |
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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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| --- | --- |
| 10. | Is there anything else you would like to tell us? |
|  |  |
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|  |  |

***Thank you for coming to our Talk-In Clinic. Please feel free to come back again.***