HÔTEL-DIEU ESTD GRACE 1888 HEALTHCARE

REGIONAL CHILDREN'S CENTRE

CLIENT INFORMATION – CHILD/YOUTH QUESTIONNAIRE
WALK-IN COUNSELLING CLINIC

Date: ______ (MM/DD/YYYY) ______

To be completed by child / youth (when able)

Name: ______________________ Birth Date: ______________ ☐ Male ☐ Female ☐ Other

Address: ____
Street City Postal Code

Parent / Guardian Name: ______________________________

Phone #: ______________________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Why are you here today? How can we help?

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2. 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 ☺

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

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4. Are you having thoughts of harming yourself or others? ☐ Yes ☐ No ☐ Maybe

5. What are you good at? What are your strengths?

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