Walk-In Therapy Clinic

Child Questionnaire (8-11 years of age)

Date: _____ **File #:**_____

Name (First) (Last)		DOB (MO,DY,YR)	Gender ___male ___female
Address	City	Postal Code	Home Phone: Cell Phone: Email:
School:	Grade:	Allergies:	Medication:

Parent/Guardian Name(s): _____ **Phone#:** _____

Family Members: _____

_____

1. Have you received services from our agency in the past? ☐ **Yes** Date:_____ ☐ **No**

2. Have you ever accessed Mental Health Crisis Services at Bluewater Health? ☐ **Yes** Date:_____ ☐ **No**

3. Who referred you to this clinic or how did you hear about this clinic?_____

4. What problem/concern would be most helpful to talk about today?

_____

_____

_____

_____

5. 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**

6. How long has this problem been around?

1 - 3 months _____ in the last year _____ longer than a year _____

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

_____

_____

_____

8. What is it like when this problem is around?

_____

_____

_____

9. Are you at any risk of hurting yourself or others: ☐ Yes ☐ No

_____

_____

_____

10. What would someone else like and respect most about you if they had a lot of time to get to know you? It is okay to guess.

_____

_____

_____

11. Is there anything you feel is important for us to know about your family's culture, ethnicity, religion, language, sexual orientation, mental or physical health, or other?

_____

_____

_____