



**Walk-In Therapy Clinic
Youth Questionnaire (12-17 Years of age)**

Date: _____

File #: _____

ABOUT YOU

| | | | |
|--|-----------------|----------------------|--|
| Name (First) _____ (Last) _____ | | DOB (MO,DY,YR) _____ | Gender: _____ |
| Self- Identification (optional): I wish to identify myself as: <input type="checkbox"/> First Nation <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Other: _____ | | | |
| Address _____ | P.O. Box: _____ | City _____ | Postal Code _____ |
| | | | Home Phone: _____ Cell Phone: _____ Email: _____ |
| School: _____ | Grade: _____ | Allergies: _____ | Medication: _____ |

ABOUT YOUR FAMILY

PARENT:

| | | | | |
|--|--|--|---------------|--|
| Name: (First) _____ (Last) _____ | | DOB: (MO,DY,YR) _____ | Gender: _____ | Home Phone: _____ Cell Phone: _____ |
| Relationship to you (mom, dad etc.): _____ | | Address (if different than yours): _____ | | |

PARENT:

| | | | | |
|--|--|--|---------------|--|
| Name: (First) _____ (Last) _____ | | DOB: (MO,DY,YR) _____ | Gender: _____ | Home Phone: _____ Cell Phone: _____ |
| Relationship to you (mom, dad etc.): _____ | | Address (if different than yours): _____ | | |

Marital Status of Parents: Single Married Common-Law Separated Divorced Widowed

Youth is currently residing with: Mother Father Grandparents Foster Care Group Home Other _____

Youth's Legal Guardian: _____

STEP-PARENTS:

| | | | |
|---------------------------|------------------------|---------------|---|
| Step-Parent's Name: _____ | DOB: (MO,DY, YR) _____ | Gender: _____ | Relationship to you (step-mom, step-dad, etc.): _____ |
| Step-Parent's Name: _____ | DOB: (MO,DY, YR) _____ | Gender: _____ | Relationship to you (step-mom, step-dad, etc.): _____ |

SIBLINGS – currently living with you: (include relationship to you – e.g. brother, half-brother etc.)

| Sib # | Name (First) _____ (Last) _____ | Relationship to you (brother, half-brother, etc) | DOB: (MO,DY,YR) |
|-------|---------------------------------|--|-----------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

GETTING READY FOR YOUR SESSION: Your answers will help us understand and work with you in the session.

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

2. Why have you come today?

3. What problem would be most helpful to talk about today?

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

5. How long has this problem been around? 1 - 3 months in the last year longer than a year

6. Are you currently at any risk of harm to yourself or to others: Yes No

7. If **1 is the WORST** and **10 is the BEST**, how are things in your life today? (please circle your response)

| | | | | | | | | | |
|-----------------|---|---|---|---|---|---|---|---|----|
| WORST..... BEST | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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

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

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