St. Clair Child & Youth Services
Empowering Mental Wellness

Walk-In Therapy Clinic
Client Questionnaire – Parent/Guardian

Date: _____ File #:_____

IDENTIFIED CHILD/CHILDREN:

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

Name (First) (Last)		DOB (MO,DY,YR)	Gender ___male ___female
Address (if different from sibling) PO Box: City Postal Code			Home Phone: Cell Phone:
School:	Grade:	Allergies:	Medication:

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

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

Child's Legal Guardian: _____

Are you currently involved in any legal process regarding custody and access: ☐Yes ☐No

Is there a legal custody agreement: ☐ Yes ☐ No

Custody Type _____ (A-Sole custody mother, B-Sole custody Father, C-Joint Custody, D-Interim, E-Other (explain)

If E-Other, Please Explain: _____

MOTHER:

Name: (First) (Last)	DOB: (MO,DY,YR)	Home Phone: Cell Phone:
Address (if different than child):		Work Phone: Email:

FATHER:

Name: (First) (Last)	DOB: (MO,DY,YR)	Home Phone: Cell Phone:
Address (if different than child):		Work Phone: Email:

STEP-PARENTS:

Step-Mother's Name:	DOB: (MO,DY, YR)
Step-Father's Name:	DOB: (MO,DY, YR)

SIBLINGS – currently living with child: (include relation – (i.e. brother/ half-brother)

Sib #	Name (First) (Last)	Relation (brother, half-brother, etc)	DOB: (MO,DY,YR)
1			
2			
3			
4			

1. Has your child or family received services from our agency in the past? ☐ Yes Date:_____ ☐ No
2. Have you ever accessed Mental Health Crisis Services at Bluewater Health for your child? ☐ Yes Date:_____ ☐ No
3. Who referred you to this clinic or how did you hear about this clinic?_____
4. List any other agencies or services involved: _____
5. Are you, your child, or anyone with you, at risk of harm to self or to others: ☐ Yes Who?_____ ☐ No
6. Is your child currently involved with the Youth Criminal Justice System? ☐ Yes ☐ No

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

_____

_____

_____

8. 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

9. How does this problem affect:

   a.) you? _____

   _____

   b.) Your child/children? _____

   _____

10. How long has this problem been around?

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

11. Imagine what will look different when the problem is not around. What will you see?

_____

_____

_____

12. Tell us about a time when you solved a problem in a way that left you feeling proud.

_____

_____

_____

13. What would someone who cares about you most appreciate about you?

_____

_____

_____

14. What do you and/or others most appreciate about your child/children?

_____

_____

_____

15. 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?

_____

_____

_____