WALK-IN COUNSELLING CLINIC
CLIENT QUESTIONNAIRE - COLLATERAL

Date: _____/_____/_____
YR MO DY

Your Name: ______________________ Your relationship to the child: ______________
Your Agency/Service Affiliation: ______________________________
Your Address: ______________________ Phone: B ______________
______________________ C ______________
city postal code

Child/Youth's name: ______________________ Gender Identify: ______________

Date of Birth: ____/____/____ Age: ______ School: ______________ Grade: __________
YR MO DY
Address: ______________________ Phone: H ______________
______________________ C ______________
city postal code

Family members: ______________________ Ages: ______________
______________________ ______________
______________________ ______________
______________________ ______________

Child's Legal Guardian: ______________________ Child lives with: ______________
*Address if different from above: ______________________________
____

Does the child attend a **Before and After School Care Program**? ☐ YES ☐ NO
If yes, provide the name of the program: ______________________________

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1. Has this family/child received services from our agency (ie. ROCK, formerly HCYS/CATC/HASS) in the past?
   ☐ YES Date: ______________ ☐ NO

2. List any other services involved:

____
____
____
____
____
____
____
____

3. What concerns do you have about this family/child?

____
____
____
____
____
____

4. How would you rate your concerns for this family/child today?
   Worst ☹ 1 2 3 4 5 6 7 8 9 10 ☺ Best

Over to Page 2

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5. What is the one problem that seems important to work on now?

6. What would be important for us to know about the background of this problem?

7. What is this family's/child's strengths?

8. What would you like to see accomplished in this meeting today?

9. In what ways do you currently provide support to this child/family?

10. In what ways could you offer further or different support?

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