ROCK™
REACH OUT CENTRE FOR KIDS

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

Date: _____/_____/_____
YR MO DY

Name: _____ Gender Identity: _____ Date of Birth: ____/____/____
First Last YR MO DY

Address: _____ Phone#: _____ ☐ Message okay?
_____ Cell #: _____ ☐ Message okay?
city postal code

Parent/Guardian Name(s): _____ Phone#: _____
Family Members: _____
School: _____ Grade: _____
Youth lives with: _____
*Address if different from above: _____

1. Have you received services from our agency (ie. ROCK, formerly HCYS/CATC/HASS) in the past or have you ever contacted our 24-hour Crisis Line before?
   ☐ YES Date: _____ ☐ NO

2. Why have you come today?
_____
_____
_____

3. 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

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

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

6. What is it like when this problem is around?
_____
_____

7. Are you currently at any risk of harm to yourself or to others? ☐ YES ☐ NO

8. What would someone else like and respect most about you if they had a lot of time to get to know you?
_____
_____
_____

9. For us to be most helpful is there anything you feel is important for us to know about your culture, ethnicity, religion, language, sexual orientation, gender identity/expression, mental or physical health, or other?
_____
_____
_____