Walk-In Therapy Clinic
Client Questionnaire- Collateral

File #:______________

Your Name: (First)____________________(Last)____________________ **Date:** _____/_____/_____
MO DY YR

Your relationship to the child:____

Your Agency/Service Affiliation: ____

Your Address: ______________________________________ **Phone: #** ____________________________

____
City Postal Code

IDENTIFIED CHILD/CHILDREN:

Name (First) (Last)			**DOB** (MO,DY,YR)	**Gender** :
Address **P.O. Box:** **City**			**Postal Code**	**Home Phone:** **Cell Phone:**
School:	**Grade:**	**Allergies:**		**Medication:**

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

ABOUT THE CHILD/CHILDREN'S FAMILY:

PARENT/LEGAL GUARDIAN:

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

PARENT/LEGAL GUARDIAN:

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

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

1. List any other agencies or services involved:

____

PREPARING FOR THE SESSION: The answers you provide will help us understand and work with the child/family in the session.

2. What concern do you have about this family/child today?

___

___

___

3. If **1 is the WORST** and **10 is the BEST**, **how would you rate your concern for this family/child?**

(please circle your response)

WORST…………………………………………………………………… BEST									
1	2	3	4	5	6	7	8	9	10

4. What is important for us to know about the background of this issue?

___

___

___

5. What are this family's/child's strengths?

___

___

___

6. What would you like to see accomplished in the Walk-In Therapy Clinic session?

___

___

___

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

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

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