**WELCOME QUESTIONAIRE**

How did you learn about our services?

 

**CHILD/YOUTH INFORMATION:**

Child/Youth’s Birth Name: 

Child/Youth’s Chosen Name: 

Child/Youth Pronouns: [ ]  He/Him [ ]  She/Her [ ]  They/Them

Child/Youth Date of Birth: 

Address (Street & Number): 

Address (City, State, Zip): 

Safe to send mail to the above address? [ ]  Yes [ ]  No

Child/Youth Telephone Contact: 

Can we leave a message at this number? [ ]  Yes [ ]  No

Email: 

Emergency Contact Name, Relation, and Number:



Insurance Provider: 

Insurance ID Number: 

What is the main reason you are seeking services?

|  |  |
| --- | --- |
| [ ] Anger/Aggression[ ] Anxiety[ ] Depression/Hopelessness[ ] Eating/Food Issues[ ] Elevated Mood[ ] Fear[ ] Grief/Bereavement[ ] Guilt[ ] Hyperactivity[ ] Loneliness[ ]  Other: | [ ] Loss of Interests[ ] Obsessive Thoughts[ ] Relationship Issues with Others:[ ] Self-Doubt/Self-Esteem[ ] Self-Harm[ ] Sleep Problems[ ] Strange Thoughts/Disturbed Reality (hallucinations, delusions, disorganized thinking)[ ] Substance or Alcohol Abuse:[ ] Suicidal Thoughts and Feelings[ ] Traumatic Stress |

Where do these problems impact you?: [ ]  Home [ ]  School [ ]  Work [ ]  With friends [ ]  All the time [ ]  Other: 

How often do these concerns occur? [ ]  Daily [ ] Weekly [ ]  Monthly [ ]  Other: 

How long have they been occurring? 

**PRIMARY CAREGIVER/GUARDIAN INFORMATION:**

Primary Caregiver/Guardian Name: 

Relation to Child: 

Phone Number: 

Can we leave a message at this number? [ ]  Yes [ ]  No

Email: 

Availability for Services (Days and Times):

