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FRONTENAC YOUTH SERVICES

WALK-IN COUNSELLING CLINIC

RETURNING CLIENT INFORMATION FORM

Please fill out this information form as carefully and thoroughly as possible. If you need any help, please ask your Intake Worker. This information is confidential and will be used by your Counsellor to assist you.

Name of Client (s):

_____ Date of Birth (MM/DD/YY): ___/___/___

_____ Date of Birth (MM/DD/YY): ___/___/___

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1. If 10 is the best and 1 is the worst, how are things in your life today?

   ☹ Worst 1 2 3 4 5 6 7 8 9 10 Best ☺

2. What is the one problem or concern that is most important for you to work on today?

   _____

   _____

   _____

   _____

3. How would you rate your ability to cope with this problem/concern?

   ☹ Very Poor 1 2 3 4 5 6 7 8 9 10 Very Well ☺

OFFICE USE ONLY

Completed Durham Central Intake Screening: ☐ Yes ☐ No Date: _____
Intake Worker: _____ YFC Assigned: _____
Session Date: _____ Last Walk In Session Date: _____
Arrival Time: _____ Start Time: _____ End Time: _____

Charitable Registration Number 13273 8691 RR0001