CENTRE Maltby CENTRE | Mental Health & Autism Services for Children & Youth
Services de santé mentale et d'autisme pour enfants et jeunes

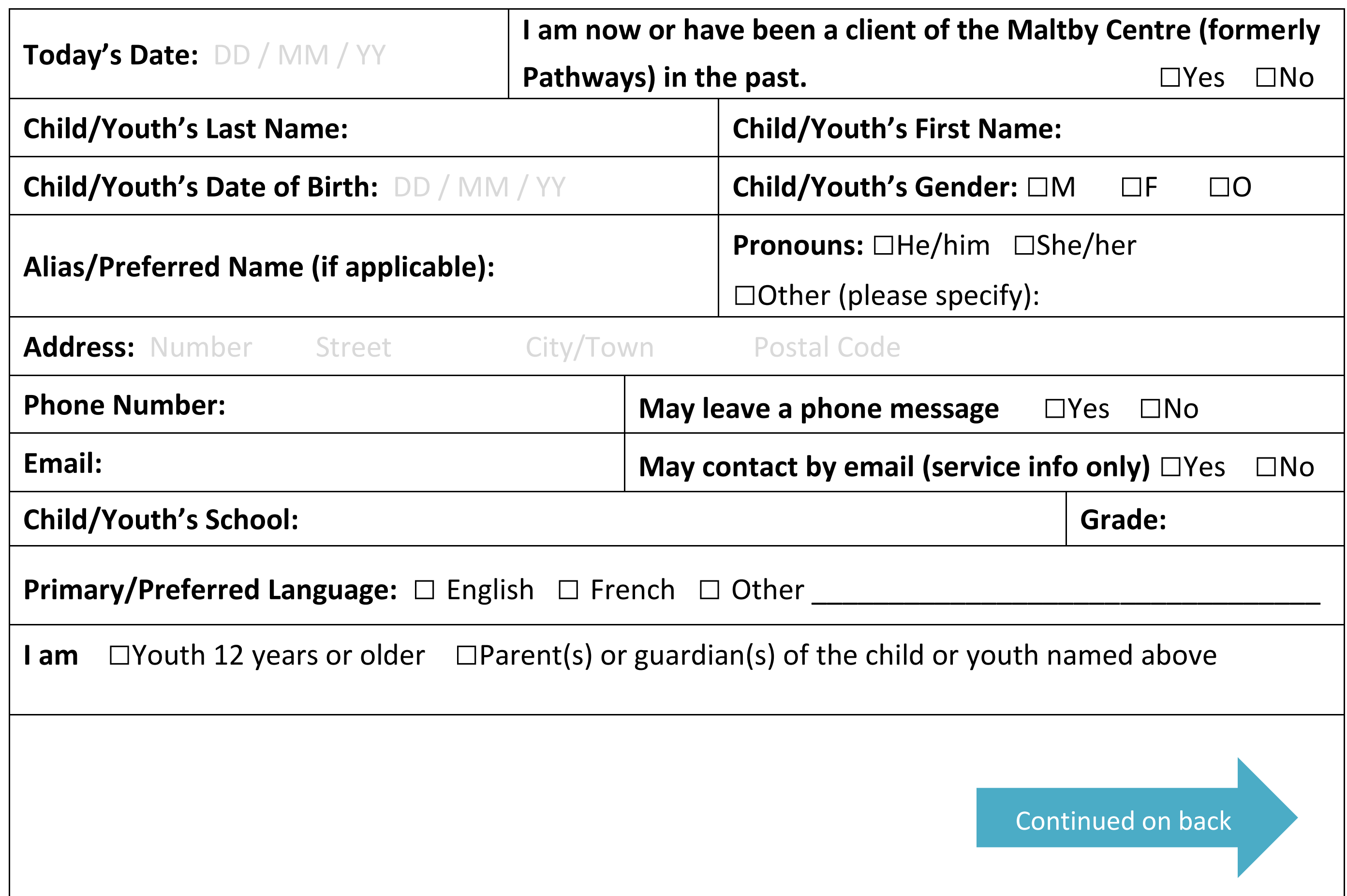
Welcome to the Maltby Centre Walk-In Clinic

What to expect:

- This single counselling session is meant to help you and your family come up with ideas to help you with the concern that brought you here today.
- You can use the Walk-In Clinic whenever you wish to address concerns that affect the mental health and wellbeing of your child (or yourself for youth 12 and over).
- If you decide you need more focused ongoing counselling services, your Walk-In Counsellor can start that process for you.

Client profile:

- Please provide the following information for our records. Your responses will let us open a file and help us get right to work helping you.
- Anything you write here or say to your Maltby Centre counsellor is confidential unless you disclose a threat to yourself or someone else in which case your counsellor will explain to you our responsibility to keep you and others safe.



Today's Date: DD / MM / YY	**I am now or have been a client of the Maltby Centre (formerly Pathways) in the past.** ☐Yes ☐No
Child/Youth's Last Name:	**Child/Youth's First Name:**
Child/Youth's Date of Birth: DD / MM / YY	**Child/Youth's Gender:** ☐M ☐F ☐O
Alias/Preferred Name (if applicable):	**Pronouns:** ☐He/him ☐She/her ☐Other (please specify):
Address: Number Street City/Town Postal Code	
Phone Number:	**May leave a phone message** ☐Yes ☐No
Email:	**May contact by email (service info only)** ☐Yes ☐No
Child/Youth's School:	**Grade:**
Primary/Preferred Language: ☐ English ☐ French ☐ Other ___________________________________	
I am ☐Youth 12 years or older ☐Parent(s) or guardian(s) of the child or youth named above	

Continued on back

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Please list the child/youth's parent/guardian. ***Please note if you are a youth 12 years or older you do not have to inform your parent/guardian of service and you may skip this section if you wish.***
Parent/Guardian Name:
Relationship to Child/Youth:
Address: ☐Same as client
Phone Number: ☐Same as client
Email: ☐Same as client
Shared Custody with another Parent/Guardian: ☐Yes ☐No
Please briefly describe the child/youth's current living situation:
What is the issue you would like help in addressing today?
What has worked so far to manage this concern?
What are your/your child or youth's three best qualities or strengths? **1.** **2.** **3.**
I agree to this walk-in counselling session. ☐Yes ☐No **I have been given a copy of the Maltby Centre Client Services Booklet and understand the risks and benefits of counselling.** ☐Yes ☐No ________________________________ ________________________ **Parent Signature** **Date** ________________________________ ________________________ **Child/Youth Signature** **Date**