# Counselling Check-in Notes

Student Name: _____ Grade: _____ Date: _____

## Scaling Questions (all out of /10)

| | | | |
|---|---|---|---|
| This Year | ___/10 | Last Year | ___/10 |
| Block 1 _____ | ___/10 | Block 2 _____ | ___/10 |
| Block 3 _____ | ___/10 | Block 4 _____ | ___/10 |

| | | | |
|---|---|---|---|
| Friends | ___/10 | Home | ___/10 |
| Mom | ___/10 | Dad | ___/10 |
| Sibling _____ | ___/10 | Sibling _____ | ___/10 |
| Relationship | ___/10 | Work | ___/10 |

| | | | |
|---|---|---|---|
| Sleep quality | ___/10 | Energy levels | ___/10 |
| Stress management | ___/10 | General mood | ___/10 |

## Safety & Risk:

Do you feel safe at school? Do you feel safe at home? Any thoughts of harming self or others?

## Quick Notes & Observations: