Child and Adolescent Questionnaire - Version 1

Note to Parents/Guardians: It is helpful for us to have your child complete as much of this questionnaire as possible. Feel free to assist them in any areas where they do not know the answer or if they have any difficulty with reading, writing, or understanding the questions.

Youth's Information:

Preferred name: _____ Age _____ Preferred Pronouns: _____ Preferred Gender Identity: _____

Parent/Legal Guardian(s) Information:

Name: _____ I currently have ❍ full custody ❍ shared custody ❍ legal guardianship.

Why did you choose to come in for services today? How are you hoping we can help you?

Were you referred for services today (ie: teacher, school counselor, doctor, hospital, police, probation, courts, etc.)?

❍ No ❍Yes - *If yes, by whom?*

MENTAL HEALTH

Please describe any mental health symptoms or difficulties that you have experienced within the past month:

Have you been diagnosed/treated for any of the following mental health disorders? ❍ No ❍ Yes *(check all that apply)*

❍ Anxiety Disorder
❍ Attention Deficit Hyperactivity Disorder
❍ Oppositional Defiance Disorder
❍ Depression
❍ Mood Disorder
❍ Post Traumatic Stress Disorder
❍ Eating Disorder
❍ Learning disability
❍ Intellectual/Developmental Delay (ie: Autism)
❍ Other: _____

Have you ever received any of the following treatments? ❍ No ❍ Yes *(check all that apply)*

❍ Outpatient services
❍ Intensive In-Home Services
❍ Mobile Crisis Stabilization
❍ Crisis Stabilization Unit
❍ Intensive Outpatient Services
❍ Partial Hospitalization Program
❍ Anger management
❍ Sex offender treatment
❍ Residential treatment
❍ Other: _____

If yes to any of the above, please list any history or current treatment providers:

Approximate Date of Admission/Discharge	Name of Provider, Practice, or Facility

Have you experienced or witnessed any of the following traumatic events in your lifetime? ❍ No ❍ Yes *(check all that apply)*

❍ Verbal abuse
❍ Emotional abuse
❍ Physical abuse
❍ Sexual abuse
❍ Rape/Sexual assault
❍ Neglect
❍ Bullying
❍ Parental addiction
❍ Parent's death
❍ Death of a loved one
❍ Physical assault
❍ Serious accident
❍ Head injury/TBI
❍ Suicide
❍ Self-harming behaviors/gestures
❍ Domestic violence
❍ Violent crime
❍ Community violence
❍ Discrimination/hate crime
❍ Natural disaster
❍ Other: _____

SUBSTANCE USE

Please indicate below if you have used the following substances in the past or currently:

Type of Substance	How much?	How often?	How do you use it? *(smoke, oral, inhale, ingest, IV)*	Age of First Use	Date of Last Use
❍ Tobacco/Nicotine (including vaping)					
❍ Alcohol					
❍ Marijuana					
❍ Ecstasy/Molly, LSD, PCP, Spice, Mushrooms, or other Hallucinogens					
❍ Amphetamine/Speed					
❍ Cocaine/Crack					
❍ Heroin					
❍ Methadone/Suboxone (not prescribed)					
❍ Opiates					
❍ Benzodiazepines (Xanax, Ativan, klonopin)					
❍ Barbiturates (Fiorcet, Seconal, Tuinal, etc.)					
❍ Other: _____					

Have you received, or are you currently receiving, any of the following services/treatment? ❍ No ❍ Yes ***(check all that apply)***

❍ Outpatient services ❍ Recovery House/Oxford house ❍ Residential Treatment

❍ Intensive Outpatient Services ❍ Inpatient Detox ❍ Other: _____

❍ Partial Hospitalization Program ❍ Medication Assisted Treatment (ie: methadone, naltrexone, suboxone, vivitrol)

If yes to any of the above, where have you received treatment?

Approximate Date of Admission/Discharge	Name of Provider, Practice, or Facility

Has anyone expressed concern about your substance use? ❍ No ❍ Yes

Do you feel like you have a problem with substances? ❍ No ❍ Yes

Have you ever experienced withdrawal symptoms for any substances you have or are using? ❍ No ❍ Yes ***(check all that apply)***

❍ Seizures ❍ Tremors/shakes ❍ Sweating ❍ Diarrhea/bloody stools

❍ Delirium tremors ❍ Muscle aches/pains ❍ Increased tolerance ❍ Other: _____

❍ Hallucinations ❍ Nausea/vomiting ❍ Binge use pattern

GENERAL AND MEDICAL HISTORY

Do you have any chronic medical conditions? ❍ No ❍ Yes *(check all that apply)*

- ❍ Alzheimer's Disease
- ❍ Anemia
- ❍ Arthritis
- ❍ Asthma
- ❍ Blood disorder/Sickle Cell
- ❍ Bowel disorder/IBS
- ❍ Cancer
- ❍ Cardiac Disease
- ❍ Chronic Pain
- ❍ Chronic fatigue
- ❍ Dementia
- ❍ Dental condition
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Fibromyalgia
- ❍ Hepatitis A, B, or C
- ❍ Headaches/Migraines
- ❍ Hearing loss
- ❍ Hyper/hypothyroidism
- ❍ High/low blood pressure
- ❍ High cholesterol
- ❍ Kidney disease
- ❍ Hypoglycemia
- ❍ Lyme disease
- ❍ Liver disease
- ❍ Pancreatic disease
- ❍ Muscle strain
- ❍ Myocardial infarction/heart attack
- ❍ Stomach ulcers/GI problems
- ❍ Pregnancy
- ❍ Stroke
- ❍ Sexually transmitted disease
- ❍ Other: _____

Are you currently taking any prescribed medications? ❍ No ❍ Yes

If yes, please list below or provide a copy of medication administration record.

Medication	Start Date	Dosage & Frequency	Rationale	Provider	Helpful? Yes/No

Have any of the reported symptoms above impacted the following areas of your life? ❍ No ❍ Yes *(check all that apply)*

- ❍ Healthcare practices
- ❍ Managing money/belongings
- ❍ Leisure
- ❍ Coping skills
- ❍ Housing stability
- ❍ Nutrition
- ❍ Community resources
- ❍ Behavior norms
- ❍ Communication
- ❍ Problem solving
- ❍ Social network/friends
- ❍ Personal hygiene
- ❍ Safety
- ❍ Family relationships
- ❍ Sexuality
- ❍ Grooming
- ❍ Managing time
- ❍ Alcohol/drug use
- ❍ Academics/productivity
- ❍ Dress

If yes to any of the above, please briefly explain:

Are there any concerns about intimate relationships, sexuality, and/or gender identification that you would like to discuss?

❍ No ❍ Yes – *if yes, please describe:*

Is there any additional information that you feel would be helpful during the assessment process?

❍ No ❍ Yes – *if yes, please describe:*