WESTERN NEVADA REGIONAL YOUTH CENTER
Family questionnaire

Hello and thank you for completing this family questionnaire. It is ok for parents/guardian to fill it out together, or for each parent to complete a separate copy. Don't worry if you agree or disagree, just be thoughtful, sincere, and honest. Research and common sense shows that having the best possible short term and long term picture of a child's life is very important to knowing how to help the child have the best possible chance to turn things around in their life. Lastly, don't worry if you do not know everything about your child's behaviors and problems. Treatment is a process of honorable discovery, based on honestly and courage. This questionnaire is one place to start! There are a lot of pages, but it is mostly blank spaces so you will have plenty of room to write what you think! Lastly, don't worry about spelling, etc, just begin.

Youth's name: ____
(Last) (First) (Middle Name)

Parent/guradian's Name:______________________ Biological _____ Step-Parent______

Phone:______________ Address:__________________________________

Parent/guardian's Name:______________________ Biological _____ Step-Parent______

Phone:______________ Address:__________________________________

Parent's Name:______________________________ Biological _____ Step-Parent______

Phone:______________ Address:__________________________________

Parent's Name:______________________________ Biological _____ Step-Parent______

Phone:______________ Address:__________________________________

Please list all family members and/or anyone else in household:

Name	Living in Home?	Sex/Age	Relationship to Client

Youth's Living Arrangements (Check all that apply in the last year)

______Lives w/both parents
______Lives w/foster family
______Lives w/one parent
______Lives w/other relatives
______Lives alone
______Other living arrangements
______Approved adults/friends
______Private residence

______Community residential facility
______Correction facility
______Homeless shelter
______Living in motels/hotels
______On the street
______ Often on runaway status
______Other Institutional setting
______ Unapproved negative friends

Check the areas of concern with the client:

__ Has had encounters w/law
__ Hard to control
__ Runs away
__ Death of family/friend
__ Destruction of objects
__ Hurts animals

__Does not obey rules/orders
__Bed wetting
__Poor sleeping/nightmares
__Frequent Lying
__Stealing
__Truancy

__ Poor academic perform
__ Withdrawn, few friends
__ Dying family/friend
__ Frequent fighting
__Physical abuse or assaultive of others
__Difficulty adjusting to a divorce/separation

__ Verbal abuse or assault occurring or suspected to this youth by other youth or adults.
__ Sexual abuse of others.
__ Substance abuse or experimentation

List other agencies and treatment programs that you are working with now or in the past:

Name	Date Entered	Completed? Yes / No	Contact Person

SCHOOL

Does the youth have a hard time concentrating or staying on task without constant reminders or consequences? Yes No If yes, explain and give examples:

Does the youth feel like he/she has a hard time figuring out what is going on in social situations such as not remembering names, hard time following conversations, outbursts that have nothing to do with the subject being discussed, inappropriate responses to questions, etc?
Yes No If yes, explain and give examples:

Does the youth get “picked on” or get victimized a lot by other youth? Yes No

Is the youth the aggressor and picks on other youth? Yes No

Overall, what types of problems does he/she experience in social situations?

What school subjects does the youth do well in?

What subjects does the youth do poorly in?

Are there any school behavior problems? If so, please explain:

School and school counselor name____

CURRENT MENTAL HEALTH TREATMENT: (Remember to bring medications to WNRYC)

Is the youth receiving mental health services now? Yes o No o

If yes, from whom? ____

What diagnosis is the youth being treated for? _______________________________________

Is the youth on any mental health medications now? Yes o No o

Medications and dosages now?____

Who prescribed them?____

Is there anything else, or other concerns you may have that we should know about current mental health services for this youth?

PRIOR MENTAL HEALTH TREATMENT:

Has the client ever received psychiatric services before? Yes o No o

If there were any mental health outpatient services rendered please list below.

	Date	Place	Reason
1.			
2.			
3.			
4.			

Has the client ever been mental health medications in the past? Yes o No o

List Medication	What Dosage?	Diagnoses

Who prescribed them and why?

If there were any other mental health hospitalizations, please list below.

	Date	Place	Reason
1.			
2.			
3.			
4.			

SUICIDE: Has the youth ever attempted suicide or done behaviors that you think might have been deliberately self destructive, such as cutting on self, deliberately overdosing on drugs/alcohol, “self choking” themselves into unconsciousness, deliberately provoking assaults as self harm, deliberate car accidents, jumping from high places, playing “chicken” with cars, etc?

Yes No If yes, explain:

Does the youth choke themselves or temporarily hang themselves as “just playing around”, to shut off oxygen to create a sexual high, or to enhance substance abuse?
Yes No
If yes, explain:

Does the youth ever deliberately harm pets or other animals? Yes No
Explain if yes:

Does the youth ever experiment or play with fire? Yes No If yes, explain:

Does the youth secretly hoard stockpiles of food, objects, clothing, etc. Yes No
Explain:

Is the youth fascinated with violence or weapons? Yes No
If yes, explain and list the weapons the youth has or owns:

Does the youth ever hear or see things that are not really there? Yes No
If yes, explain what is seen or heard:

Have you strongly suspected, or has anyone ever accused the youth of touching another person in a sexually **inappropriate** manner or of "exposing" themselves sexually to others?
Yes No If yes, explain:

Does the youth have an unusual collection or fascination with pornography, steal underwear, or do other sexual behaviors that most people would see as unusual or unsafe?
Yes No If yes, explain:

HISTORY OF NEUROLOGICAL PROBLEMS:

Has the youth ever been involved in an accident, fall, sporting activity, car accident, or physical assault where there was a blow to the head? Yes o No o

Did the blow result in loss of consciousness? Yes No

Has the youth lost consciousness due to blood loss, or medical problems? Yes No

How long was the youth unconscious?

Did the youth see a doctor for this incident. Yes No If yes, what was the finding?

Has the youth ever had seizures? Yes o No o

Were these seizures drug or alcohol related? Yes o No o

Has the youth been treated for these seizures? Yes o No o

IMMEDIATE FAMILY HISTORY

Has the youth ever been or currently is a victim of domestic violence? Including sexual assault?
Yes o No o If yes, please explain:

Is there a family history of a restraining/no-contact court order? Yes No
If yes, please explain why and for how long:

Biological Father
Has father been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does he have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Biological Mother
Has mother been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does biological mother have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Step Father

Has stepfather been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does he have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Step Mother

Has stepmother been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does she have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Siblings

Has a sibling been treated for any addiction? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

Does sibling he/she have a history of mental illness? Yes o No o If yes, what was the diagnosis and outcome of treatment?

How was/is it being treated?

EXTENDED FAMILY HISTORY OF ADDICTION OR MENTAL ILLNESS:

Long term multi-generational family history is very important to understanding and treating a youth's addictions and mental health needs. Please briefly explain the biological mother's and father's family history of addictions and mental health issues:

1. What mental health or substance abuse issues exist or existed in the mother's side of the family, and for whom?

2. What mental health or substance abuse issues exist or existed in the father's side of the family, and for whom?

MEDICAL/DENTAL ISSUES (Remember to bring youth's medications to WNRYC)

Does the youth have any allergies? Yes No If yes, describe:

Is the youth currently in the care of a doctor for any health problems? Yes No
If yes, explain:

Is the youth currently taking medication for BEHAVIORAL reasons?

Yes No If yes, explain what medication, the dose, and what it is for:

Is the youth currently taking medication for MEDICAL reasons?

Yes No If yes, explain what medication, the dose, and what it is for:

History of severe illness/injury: Yes No

Type of severe illness or injury:

Medications used for this illness or injury:

Describe any long term effects that may exist due to this severe illness or injury:

IMMUNIZATIONS

Immunizations: All are current________ Some are done and some are not done_________

Explain if not done:

Does the youth have any current medical problems? If yes, what are they?

When was the last time the youth saw a prescribing physician?

Is their medication currently being monitored? Yes No If yes, how is it being monitored?

In the last 5 years, how many visits to the E.R.________? Admitted as Outpatient________? Hospitalized Inpatient________? What were the reasons?

When was the youth's last physical exam before the recent WNRYC Physical, and what was the results?

Does the youth have any physical disabilities or major limitations? (check all that apply)

- o None
- o Mobility
- o Hearing
- o Learning
- o Vision
- o Mental / psychological
- o Speech
- o Developmental
- o Other

Please explain those checked:

Youth's regular physician name, address, phone:

Youth's regular dentist name, address, phone:

Other preferred emergency care providers:

MEDICAL INSURANCE

Name of Insured____

____

Company Policy Number

Please provide a copy of insurance card. (We can make a copy for you free of charge.)

YOUR OPINION AND FEELINGS

Instructions: This is your page to simply summarize your personal opinion and feelings about the youth and your family. Please be honest, and help us to see the bigger picture. This will help us help you.

How does your family get along?

Describe one really good time and one really bad time in your family:

What kind of family problems are you experiencing within the home?

How can this program help you and your family at home?

What else, if anything, should we know about your young person and the family so that we can really help you in the treatment process?

Thanks for taking the time to complete this questionnaire, it will really help!