PRE-ADMISSION QUESTIONNAIRE (CHILD/ADOLESCENT)

Client Name (First, MI, Last)	Client No.

Living Situation

Parent's Home
☐ Rent ☐ Own

****Residential Care/Treatment Facility**
☐ Hospital ☐ Temporary Housing ☐ Residential Care ☐ Nursing Home

****Other**
☐ Friend's Home ☐ Relative's/Guardian's Home ☐ Foster Care Home ☐ Respite Care ☐ Jail/Prison
☐ Homeless Living with Friend ☐ Homeless in Shelter/No Residence ☐ Other:

****Identify Facility or Person's Name**

Primary Household

Household Member Names	Relationship to Client	Age	Occupation/School	Level of Education	Quality of Relationship

Street Address (if different from client's address listed on Demographic Information form)

Secondary Household

Does client live in more than one household?
☐ No If no, skip to "Additional Family Members"
☐ Yes If yes, complete the secondary household information below.

Household Member Names	Relationship to Client	Age	Occupation/School	Level of Education	Quality of Relationship

Secondary Household Street Address (if different from client's address listed on Demographic Information form)

Family Members Who Live in Both Households
☐ Only Client ☐ Client and (list):

Additional Family Members (i.e., parents or siblings not living in primary or secondary households)
☐ No Parents or Siblings Other Than Those Listed in Primary or Secondary Households

Custody and Parenting Plan
☐ Lives with Both Parents (biological or adoptive) in Same Household or with Widowed Parent
☐ Other (describe):

Client Name (First, MI, Last)	**Client No.**

Family Environment/Relationships

Parent-Child (Client) Relationship(s): P = Primary Household S = Secondary Household B = Both

Parent-Child Conflict:	None-Mild		Moderate	Severe	
Parent Supervision and Monitoring of Child:	Always	Usually	Inconsistently	Rarely	
Cooperation Between Parents Regarding Child-Rearing:	Always	Usually	Inconsistently	Rarely	Not Pertinent
Parent Positive Activities with Child:	Frequent		Occasional	Infrequent	
Parent Satisfaction with Relationship:	Satisfied		Neutral	Dissatisfied	
Child Satisfaction with Relationship:	Satisfied		Neutral	Dissatisfied	

Comment on Parent-Child Relationships (describe further if needed)

Sibling-Child (Client) Relationship(s) No Siblings P = Primary Household S = Secondary Household B = Both

Child-Sibling(s) Conflict:	None-Mild	Moderate	Severe
Sibling(s) Positive Activities with Child:	Frequent	Occasional	Infrequent
Sibling(s) Satisfaction with Relationship:	Satisfied	Neutral	Dissatisfied
Child Satisfaction with Relationship:	Satisfied	Neutral	Dissatisfied

Parent Marital or Couples Relationship(s) ☐ Not Applicable in this Case P = Primary Household S = Secondary Household B = Both

Marital or Couples Conflict:	None-Mild	Moderate	Severe
Marital or Couples Satisfaction:	Satisfied	Neutral	Dissatisfied

Other Family Concerns

Family Member Alcohol Abuse:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other
Family Member Substance Abuse:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other
Family Member Mental Health Problems:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other
Family Member Health Problems:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other
Family Member Disability:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other
Family Member Legal Issues:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other
Family Member Financial Concerns:	☐ No	☐ Yes	If yes, indicate:	☐ Parent	☐ Sibling	☐ Other

School Functioning

Educational Classification

Regular Education Classroom, No Special Services

☐ No (If no, check all that apply.) ☐ Yes

☐ 1 Multiple Disabilities (not deaf-blind)	☐ 06 Orthopedic Impairment	☐ 12 Autism
☐ 2 Deaf-Blindness	☐ 08 Emotional Disturbance (SBH)	☐ 13 Traumatic Brain Injury
☐ 3 Deafness (hearing impairment)	☐ 09 Mental Retardation (DH)	☐ 14 Other Health Impaired (major)
☐ 4 Visual Impairment	☐ 10 Specific Learning Disability	☐ 15 Other Health Impaired (minor)
☐ 5 Speech or Language Impairment	☐ 11 Preschoolers with a Disability	☐ Current 504 Plan
☐ Other:		

Legal History

Current Legal Status

☐ None Reported ☐ On Probation ☐ Detention ☐ On Parole ☐ Awaiting Charge
☐ A or D Related Legal Problems ☐ Court Ordered to Treatment ☐ Other:

History of Legal Charges

☐ No ☐ Yes If yes, check and describe: ☐ Status Offense (e.g., Unruly)
☐ Delinquency

Name of Probation/Parole Officer (if applicable):

Client Name (First, MI, Last)	**Client No.**

Adjudications

☐ No ☐ Yes

If yes, describe:

Detentions or Incarcerations

☐ No ☐ Yes

If yes, describe:

Civil Proceedings

☐ No ☐ Yes

If yes, describe:

Domestic Relations Court Involvement

☐ No ☐ Yes

If yes, describe:

Juvenile Court Involvement (related to child abuse, neglect, or dependency)	**Case Worker Name** (if applicable)
Current: ☐ No ☐ Yes Comment: _____ Past: ☐ No ☐ Yes Comment: _____	

Children's Protective Services Involvement with Family

☐ No ☐ Yes

If yes, describe:

Name of CPS Caseworker(s) Assigned to Family (if applicable)

None

Name of Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family

☐ None

Employment

☐ Not Pertinent - Skip this Section

Currently Employed? If yes, name of employer: ☐ Yes ☐ No	Job Title

Employment Interests/Skills/Concerns

Mental Health Treatment History ☐ **None**

Outpatient Mental Health Treatment ☐ **None**

Agency	Check if Current	Past (Date)	Clinician Name

Psychiatric Hospitalizations/Residential Treatment Facilities ☐ **None**

Facility	Date of Service	Reason (suicidal, depressed, etc.)

Previous or Current Diagnoses (if known)

☐ Not Known

☐ None **Current Medication** (prescription/OTC/herbal)

Medication	Rationale	Dosage/Route/Frequency	Compliance			
			Yes	No	Partial	Unk

Primary Care Physician (name, phone no., and address)

Date of Last Physical Exam

Other Prescribing Physician(s) (name, phone no., and address)

☐ None **Past Psychotropic Medications**

Psychotropic Medications	Reason for Discontinuation

Alcohol/Drug History

Illegal drug use/abuse past 12 months? ☐ No ☐ Yes

Prescription drug abuse past 12 months? ☐ No ☐ Yes

Non-prescription drug abuse past 12 months? ☐ No ☐ Yes

Alcohol use/abuse past 12 months? ☐ No ☐ Yes

Toxicology screen completed?

☐ No ☐ Yes If yes, results:

Presenting with detox issues?

☐ No ☐ Yes If yes, symptoms:

Check All That apply

IV Drug User Pregnant Other Addictive Behaviors:

Drug/Substance/Alcohol/Tobacco	Age of First Use	Date of Last Use	Frequency of Use	Amount	Method

Alcohol/Drug Treatment History

AoD Treatment

☐ None

Current: ☐ Outpatient ☐ Intensive outpatient ☐ Residential ☐ Other:

Past: ☐ Outpatient ☐ Intensive outpatient ☐ Residential ☐ Hospital ☐ Detox ☐ Other:

If current or past complete the following:

Name of Provider Agency	Type of Service	Date of Service

Abuse History (describe in space below)

☐ No Self Reported History of Abuse/Violence ☐ Physical Abuse ☐ Domestic Violence/Abuse ☐ Community Violence

☐ Physical Neglect ☐ Emotional Abuse ☐ Sexual Abuse/Molestation

☐ Other: