

Gulf Coast Behavioral Clinic

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Welcome to Gulf Coast Behavioral Clinic!

Dear Parent/Guardian, the information you provide here will help your provider in identifying your child's needs and how to best serve your family.

Please complete the assessment forms prior to the day of your appointment.

Please be prepared to arrive 1 hour early to complete clinic paperwork upon arrival if not completed prior to your appointment.

If you cannot keep this appointment, please call to cancel within 24 hours before your appointment date and time. If you fail to do so, you may not be allowed to reschedule your appointment.

IMPORTANT things to bring on the day of your appointment:

- **Your completed paperwork**
- **A form of ID such as a driver's license (Adult) or school ID (child)**
- **Current insurance card**
- **All current medication in their original bottle**

Thank you for choosing GCB Clinic for your healthcare needs and we look forward to serving you!

PARENT OR GUARDIAN – PLEASE COMPLETE AND BRING THIS FORM TO CLINIC

Gulf Coast Behavioral Clinic

Behavioral Health Child/Adolescent Intake Form

Child Name (First, MI, Last)		Age	Date of Birth
School		Grade	Today's Date
Primary M.D.	Social Worker	County	
Who Referred You?			
<p>What are the current concerns? List in order of importance. Please include changes in mood, behavior, sleep, eating, free time activities, school concerns, etc.)</p> <p>1. _____</p> <p>_____</p> <p>2. _____</p> <p>_____</p> <p>3. _____</p> <p>_____</p>			
Mental Health Treatment History		Place(s) and Date(s)	
<input type="checkbox"/> Psychiatric Consultation			
<input type="checkbox"/> Outpatient Therapy/Counseling			
<input type="checkbox"/> Inpatient Hospitalization			
<input type="checkbox"/> Partial Hospitalization (Hospital-Based)			
<input type="checkbox"/> Day Treatment (Alternative School or School-Based)			
<input type="checkbox"/> Chemical Dependency Treatment			
<input type="checkbox"/> In-home Family Therapy			
<input type="checkbox"/> Psychological testing (IEP, IQ, achievement, etc.)			
Are there other ways that your family has attempted to deal with the concerns?			
1. _____			
2. _____			
3. _____			

SYMPTOM CHECKLIST: Read each item below and decide how much you think your child/adolescent has been showing the problem during the past month. (0 = Not at all 1 = Rarely 2 = Sometimes 3 = Often)

NEURODEVELOPMENTAL SYMPTOMS

	Fails to give close attention to details or makes careless mistakes in schoolwork, work, or activities
	Has difficulty sustaining attention in tasks or play activities
	Does not seem to be listening when spoken to directly
	Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
	Has a difficult time organizing tasks and activities (e.g. managing sequential tasks, organizing materials, etc.)
	Avoids or dislikes or is reluctant to engage in tasks that require sustained mental effort
	Loses things necessary for tasks or activities
	Is distracted by extraneous stimuli (for adolescents and adults this may include unrelated thoughts)
	Is forgetful in daily activities (e.g., doing chores, running errands, keeping appointments, etc.)
	Fidgets with or taps hands and feet or squirms in seat
	Leaves seat in situations when remaining seated is expected
	Runs about or climbs in situations where it is inappropriate (or feelings of restlessness in adolescents/adults)
	Unable to play or engage in leisure activities quietly
	Is "on the go", acting as if "driven by a motor" (e.g. unable to sit still for extended periods of time)
	Talks excessively
	Blurts out an answer before a question has been completed
	Has difficulty waiting his or her turn
	Interrupts or intrudes on others (e.g. butts into games, conversations or activities, uses others' things)
	Intellectual or cognitive impairment or delays
	Speech or language problems
	Has difficulty in reading (word reading accuracy, reading rate or fluency, reading comprehension)
	Has difficulty in mathematics (number sense, memorization of math facts, accuracy or fluency, reasoning)
	Has difficulty in written expression (spelling, grammar/punctuation, clarity or organization)
	Motor/coordination problems
	Vocal/motor tics (e.g., repetitive eye blinking, throat clearing, facial movements, noises, etc.)
	Has difficulty with social communication and social interaction across multiple contexts/settings. IF YES, CHECK THOSE BELOW THAT APPLY.
	<input type="checkbox"/> Deficits in social-emotional interactions (e.g. approaching others abnormally, failing to converse back and forth, doesn't share interests or feelings, fails to initiate or respond to social interactions, etc.)
	<input type="checkbox"/> Deficits in nonverbal communication (e.g. abnormal eye contact or body language, lack of facial expression, trouble understanding or using gestures)
	<input type="checkbox"/> Trouble developing or keeping friendships at a level expected for developmental age
	Restricted, repetitive patterns of behavior, interest, use of objects or speech. IF YES, CHECK THOSE BELOW THAT APPLY.
	<input type="checkbox"/> Repetitive patterns of behavior, interests, use of objects, or speech.
	<input type="checkbox"/> Repetitive or unusual motor movements, use of objects or speech
	<input type="checkbox"/> Insistence on things being the same, inflexible routines or patterns of verbal/nonverbal behavior
	<input type="checkbox"/> Highly restricted interests that are abnormal in intensity or focus
	<input type="checkbox"/> Under or over-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. indifference to pain/temperature, over response to textures, smells, light, movement, sounds, or tastes)

DISRUPTIVE BEHAVIOR SYMPTOMS	
	Loses temper
	Touchy and easily annoyed
	Angry and resentful
	Argues with adults
	Actively defies or refuses to comply with rules or requests from authority figures
	Deliberately annoys others
	Blames others for own mistakes or misbehavior
	Spiteful or vindictive
	Behavioral outbursts involving verbal or physical aggression
	Bullies, threatens or intimidates other
	Initiates physical fights
	Used a weapon that can cause serious physical harm to others
	Physically cruel to people or animals
	Has stolen while confronting a victim
	Forced someone into sexual activity
	Deliberately engaged in fire setting with the intention of causing damage
	Deliberately destroyed others' property
	Broke into someone's house, building, or car
	Lies in order to obtain favors or to avoid obligations
	Has stolen without confrontation (e.g., forgery, shoplifting)
	Stays out at night without permission
	Has run away from home overnight
	Has been truant
	Verbal aggression or physical aggression toward property, animals, or other individuals, not resulting in physical injury to animals or other individuals.
	Behavioral outbursts involving damage or destruction of property and/or physical assault involving injury against animals or other individuals within a 12 month period.
MOOD SYMPTOMS	
	Temper outbursts manifested verbally and/or behaviorally, that are out of proportion to the situation and are inconsistent with developmental level
	The mood in between temper outbursts is persistently irritable or angry
	Depressed or irritable mood
	Less interest or pleasure in all or almost all activities
	Significant weight loss when not dieting or weight gain (greater than 5% of body weight in a month)
	Difficulty sleeping or oversleeping
	Increased movement and agitation or decreased movement and slowing down
	Fatigue or loss of energy
	Feelings of worthlessness or excessive and inappropriate guilt
	Difficulty thinking or concentrating, or indecisiveness
	Thoughts of death, or suicidal thoughts (with or without a specific plan), or suicide attempt(s)
	Has had a <i>distinct</i> period of abnormally and persistently elevated (happy, excited) or irritable mood <i>and</i> abnormally and persistently increased goal-directed activity or energy. IF YES, CHECK THOSE BELOW THAT APPLY.
	<input type="checkbox"/> At least 4 days of noticeably increased, inflated self esteem or grandiosity
	<input type="checkbox"/> At least 4 days of noticeably decreased need for sleep (e.g. feels rested on 3 hours of sleep)
	<input type="checkbox"/> At least 4 days of noticeably increased talkativeness or pressure to keep talking
	<input type="checkbox"/> At least 4 days of noticeably increased racing thoughts or flight of ideas
	<input type="checkbox"/> At least 4 days of noticeably increased distractibility
	<input type="checkbox"/> At least 4 days of noticeably increased goal-directed activity or motor agitation (purposeless activity)
	<input type="checkbox"/> At least 4 days of noticeably excessive involvement in high risk activities

ANXIETY SYMPTOMS	
	Fear and anxiety concerning separation from home or major attachment figures
	Failure to speak in certain social situations (e.g., school or with unfamiliar adults) but speaking ok at home
	Marked fear/anxiety about a specific object or situation (e.g., heights, animals, the dark)
	Marked fear/anxiety about social situations involving being observed by others (e.g., performing, conversing)
	Panic attacks (sudden onset of intense fear or physical discomfort that reaches a peak within minutes)
	Anxiety and worry about a number of events or activities, occurring more days than not
OBSESSIVE-COMPULSIVE SYMPTOMS	
	Recurrent and persistent thoughts, urges, or images that cause marked anxiety or distress
	Repetitive behaviors (e.g., hand washing, checking) or mental acts (e.g., praying, counting) that the individual feels driven to perform in response to an obsession or according to rules that must be rigidly applied
	Preoccupation with perceived defects or flaws in physical appearance that are not observable to others
	Difficulty discarding or parting with possessions, regardless of their value (i.e., hoarding)
	Hair pulling
	Skin picking
TRAUMA- AND STRESSOR- RELATED SYMPTOMS	
	Has experienced a pattern of extreme, insufficient care (e.g., neglect, deprivation, changes in caregivers, etc.) IF YES, CHECK THOSE THAT APPLY
	<input type="checkbox"/> Rarely or minimally seeks or responds to comfort from caregivers when upset or distressed
	<input type="checkbox"/> Minimal social and emotional responsiveness to others
	<input type="checkbox"/> Limited positive emotions
	<input type="checkbox"/> Episodes of unexplained irritability, sadness or fearfulness during interactions with adult caregivers
	<input type="checkbox"/> Reduced caution in approaching and interacting with unfamiliar adults
	<input type="checkbox"/> A pattern of actively approaching and interacting with unfamiliar adults (e.g., a willingness to go off with unfamiliar adults with little or no hesitation, being overly familiar, not checking back with caregivers after venturing away, etc.)
	Has had exposure to actual or threatened death, serious injury, or sexual violence IF YES, CHECK THOSE THAT APPLY
	<input type="checkbox"/> Recurrent, distressing memories or dreams of the traumatic event
	<input type="checkbox"/> Re-enactment of the traumatic event in repetitive play activities
	<input type="checkbox"/> Intense, physical or emotional distress when exposed to reminders of the traumatic event
	<input type="checkbox"/> Flashbacks of the traumatic event (i.e., feeling or acting as if the traumatic events were recurring)
	<input type="checkbox"/> Persistent avoidance of memories, thoughts, feelings, places or objects associated with the traumatic event
	<input type="checkbox"/> Negative changes in thoughts or mood beginning or worsening after the traumatic event (e.g., guilt, shame, loss of interest, feeling detached, self-blame, etc)
	<input type="checkbox"/> Marked changes in arousal or reactivity, beginning or worsening after the traumatic event (e.g. angry outbursts, hypervigilance, problems sleeping, reckless/destructive behavior, etc.)
DISTORTED THINKING OR PERCEPTION SYMPTOMS	
	Delusions (i.e., persistent odd or false beliefs)
	Hallucinations (i.e., hearing or seeing things that are not really there)
DISORDERED EATING SYMPTOMS	
	Episodes of binge eating
	Inappropriate behaviors used to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives or diuretics, fasting, excessive exercise, etc.)
	Restriction of food intake leading to significantly low body weight (i.e., less than minimally expected)
	Fear of gaining weight or becoming fat
	Disturbance in the way in which one's body weight or shape is experienced

GENDER DYSPHORIA SYMPTOMS

Incongruence between one's experienced/expressed gender and actual gender, of at least 6 months duration

MISCELLANEOUS SYMPTOMS

Are there other symptoms or concerns that you have about this child/adolescent?

Risk Indicators (Check all that apply)

Wish to be Dead: has had thoughts about a wish to be dead or not live anymore, or a wish to fall asleep and not wake up.

Suicidal Thoughts: has had non-specific thoughts of wanting to end life/die by suicide.

Suicide Behavior: has had an actual suicide attempt, an interrupted attempt, or other preparatory acts to kills self

Self-injurious behavior **without** suicidal intent

Method for suicide available (gun, pills, etc.)

 No firearms in the home Firearms are easily accessed Use of safe firearm and ammunition storage practices

Family history of suicide (lifetime)

Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)

Arrests/Pending incarceration

Current or pending isolation or feeling alone

Hopelessness

Command hallucinations to hurt self

Highly impulsive behavior

Drug or alcohol abuse/dependence

Perceived burden on family or others

Chronic physical pain or other acute medical problem

Homicidal thoughts/preoccupation with violence

Aggressive behavior toward others

Sexual abuse (lifetime)

Unhealthy peer group

Inappropriate sexual activity

Current Living SituationParent's name: Age: Biological Adoptive Step

Address: City: State:

Lives with the child/adolescent? Yes No If not, where does he/she live?Employed outside of the home? Yes No Occupation: Hours/wk:Parents's name: Age: Biological Adoptive Step

Address: City: State:

Lives with the child/adolescent? Yes No If not, where does he/she live?Employed outside of the home? Yes No Occupation: Hours/wk:Parents' marital status: never married. married for ____ years. separated. divorced.

If parents are divorced, describe physical and legal custody?

Other parent(s) or caregiver(s) names (if different from above):

Relationship to patient:

Relationship to patient:

Is the caregiver employed outside the home? Yes No Occupation: Hours/wk:

Legal guardian of patient, if other than biological parent(s):

List all people this child/adolescent is presently living with:

Name	Age	Relation	Health Status:
			Good/Fair/Poor

List any immediate family members who do not live with this child/adolescent and any deceased family members:

Name	Living	Age	Relation	City, State
	Y/N			

Developmental History

Prenatal and Delivery History

How was the mother's overall health during pregnancy with this patient?: good fair poor don't know

How was the mother's overall health during pregnancy with this patient?: good fair poor don't know

Did the mother experience any medical problems or complications during pregnancy? Yes No

If yes, please specify:

How old **were** the parents when this patient was born? Mother _____ Father _____

What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?

Alcohol: Describe amount and frequency. _____

Tobacco: Describe amount and frequency. _____

Street Drugs: Describe what drugs, amount and frequency. _____

Prescription Drugs: Describe what drugs, amount and frequency. _____

Was this child/adolescent born: less than 30 weeks gestation 30-35 weeks 36-40 weeks over 40 weeks

Was delivery: Normal Breech Caesarian Forceps/vacuum assisted Induced

What was the child/adolescent's birth weight? _____

Were there indications of fetal distress during labor/birth? Yes No

If yes, please specify _____

Were there any health complications following birth? Yes No

If yes, please specify _____

Postnatal Period and Infancy

Were there any infancy feeding problems? Yes No

If yes, please specify _____

Was this child/adolescent colicky as an infant? Yes No

If yes, please specify _____

Were there infancy sleep pattern difficulties? Yes No

If yes, please specify _____

Were there problems with responsiveness/alertness during infancy? Yes No

If yes, please specify _____

How easy was this child/adolescent as a baby?

Very easy Easy Average Difficult Very Difficult

Were there any concerns about this child/adolescent's attachment to the primary caregiver(s)? Yes No

If Yes, please specify _____

Toddler Period

As an infant/toddler, how did this child/adolescent behave with other people?

More sociable than average Average sociability Actively avoided socializing More shy than average

As an infant/toddler, how insistent was this child/adolescent when he or she wanted something?

Very insistent Somewhat insistent Average Passive

As an infant/toddler, how active was this child/adolescent?

Very active Active Average Less active Very inactive

How would you describe this child's play as an infant/toddler? (Check all that apply)

Loud Interested in playing with others Imaginative / Make believe

Quiet Played alone Repetitive Rigid, concrete

Developmental Milestones

Have you or anyone else ever had concerns about this child/adolescent's development? Yes No

If yes, please specify _____

At what age (in months) did this child/adolescent:

Sit up? _____ Crawl? _____ Walk? _____

At what age (in months) did this child/adolescent speak single words (other than "Mama" or "Dada")? _____

At what age (in months) did this child/adolescent begin stringing two or more words together? _____

At what age (in months) was this child toilet trained? For bladder _____ For bowel _____

Medical History

How would you describe your child/adolescent's health?

Very Good Good Fair Poor Very Poor

How is his/her hearing? Good Fair Poor Fine motor coordination? Good Fair Poor

Vision? Good Fair Poor Gross motor coordination? Good Fair Poor

Speech and language? Good Fair Poor

Has this child/adolescent ever had chronic health problems (e.g., asthma, diabetes, allergies, heart condition)? Yes No
If yes, please specify _____

Which of the following illnesses has this child/adolescent had? Check all that apply:

Chronic diarrhea Stomach aches High fevers Chronic pain Chronic ear infections
 Constipation Allergies Encephalitis Chronic headaches Lead poisoning
 Asthma Croup RSV Chicken pox Urinary tract infections
 Pneumonia Seizures Meningitis Other _____

Has this child/adolescent had any medical problems aside from the usual childhood illnesses? Yes No
If yes, please specify _____

Has this child/adolescent ever been hospitalized? Yes No

If yes, please specify the reason, date, outcome and name of hospital. _____

Has this child/adolescent ever had any emergency room visits for emotional or behavioral problems? Yes No

If yes, please specify the reason, date, outcome and name of hospital. _____

Has this child/adolescent ever received medication for emotional, physical, learning or behavioral problems? Yes No

If yes, please specify:

Medication #1: _____

Reason prescribed? _____

Daily Dose: _____

Who Prescribed This?: _____

How long was this taken?: _____

Was this helpful? _____

Side effects: _____

Medication #2: _____

Reason prescribed? _____

Daily Dose: _____

Who Prescribed This? _____

How long was this taken? _____

Was this helpful? _____

Side effects: _____

Medication #3: _____

Reason prescribed? _____

Daily Dose: _____

Who Prescribed This? _____

How long was this taken? _____

Was this helpful? _____

Side effects: _____

Medication #4: _____

Reason prescribed? _____

Daily Dose: _____

Who Prescribed This? _____

How long was this taken? _____

Was this helpful? _____

Side effects: _____

Medication #5: _____ Reason prescribed? _____ Daily Dose: _____ Who Prescribed This? _____ How long was this taken? _____ Was this helpful? _____ Side effects: _____	Medication #6: _____ Reason prescribed? _____ Daily Dose: _____ Who Prescribed This? _____ How long was this taken? _____ Was this helpful? _____ Side effects: _____
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Has this child/adolescent had any accidents resulting in the following? (Check all that apply)

<input type="checkbox"/> Sutures	<input type="checkbox"/> Broken bones	<input type="checkbox"/> Severe lacerations	<input type="checkbox"/> Head injury
<input type="checkbox"/> Severe bruises	<input type="checkbox"/> Loss of teeth	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Eye injury

Please explain the injury: _____

Does this child/adolescent have any bladder control problems?: No Yes

If yes, are these ... During the day? During the night?

Does this child/adolescent have any bowel control problems?: No Yes

If yes, are these ... During the day? During the night?

This child/adolescent's usual bedtime is at: _____ when in school. _____ when on vacation.

Describe this child/adolescent's sleep patterns or habits:

<input type="checkbox"/> Sleeps all night without disturbance	<input type="checkbox"/> Has trouble falling asleep	<input type="checkbox"/> TV in bedroom	<input type="checkbox"/> Early morning awakening
<input type="checkbox"/> Awakens during night/restless sleeper	<input type="checkbox"/> Screen time up to bedtime	<input type="checkbox"/> Severe snoring	<input type="checkbox"/> Sleeps outside bedroom
<input type="checkbox"/> Gets out of bed in middle of the night	<input type="checkbox"/> Sleeps with parent(s)		

Describe this child/adolescent's eating habits:

<input type="checkbox"/> Overeats	<input type="checkbox"/> Average	<input type="checkbox"/> Under eats	<input type="checkbox"/> Binge eating	<input type="checkbox"/> Intentionally restricts intake
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Family Health History

	Mother	Father	Sibling	Describe the disability or health problem
Family member disability?				
Family member serious health problems? (Heart defects, heart arrhythmias, sudden death at a young age, etc.)				

Family Mental Health History

Check all that apply to biological family	Mother	Maternal family	Father	Paternal family	Siblings
Heart Problems					
Thyroid Problems					
Problems with inattention, hyperactivity/ impulse control.					
Problems with aggression, oppositional, or antisocial behavior as a child.					
Learning disabilities					
Cognitive/intellectual disabilities					
Autism Spectrum					
Anxiety					
Depression					
Obsessive Compulsive Disorder					
Eating Disorder					
Schizophrenia or Psychosis					
Bipolar Disorder					
Suicidal thoughts or attempts					
Drug abuse or dependence					
Victim of sexual abuse					
Victim of physical abuse					
Other: (specify)					

Cultural, Spiritual Influences

Describe any important spiritual/religious/cultural influences that are important in understanding this child/adolescent's problems or treatment: _____

Life Stressors/Trauma History

Has this child/adolescent experienced or witnessed any of the following? (Check all that apply)

- Domestic violence/abuse: Explain _____
- Community violence: Explain _____
- Physical abuse: Explain _____
- Verbal or Emotional abuse: Explain _____
- Sexual assault/molestation: Explain _____

- Physical neglect: Explain _____
- Serious illness: Explain _____
- Serious accident : Explain _____
- Divorce/Separation/Remarriage of Parent: Explain _____
- Change of residence: Explain _____
- Change of schools: Explain _____
- Job changes of parents: Explain _____
- Pregnancy/Miscarriage/Abortion: Explain _____
- Family chemical abuse: Explain _____
- Exposure to drug activity (outside of the home): Explain _____
- Foster care or other out-of-home placement: Explain _____
- Arrests/Imprisonments in family: Explain _____
- Death/loss of family member: Explain _____
- Death/loss of friend: Explain _____
- Family accident or illness: Explain _____
- Financial changes or stressors: Explain _____
- Parent conflicts in disciplining: Explain _____
- Other: Explain _____

Strengths and Quality of Social Network

What are this child/adolescent's strengths?

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

What does this child/adolescent like to do?

Activities: _____

Hobbies: _____

Describe this child/adolescent's relationship with each parent:

Mother: _____

Father: _____

Step mother: _____

Step father: _____

Other caregivers: _____

Describe this child/adolescent's relationship with siblings:

Describe this child/adolescent's relationship with peers:

Describe the parent relationship and any impact on this child/adolescent:

Educational History

Does your child/adolescent have a 504 plan or IEP for special education services?: No Yes

If no, has your child ever been tested and determined not to need services? No Yes

Did the child ever have IQ or achievement testing? Yes or No _____

Please summarize your child/adolescent's academic, behavioral and emotional progress within each of these grade levels. Please include any teacher observations.

Grade	Progress	School/Program
Preschool/ Daycare		
Kindergarten		
1 st grade		
2 nd grade		
3 rd grade		
4 th grade		
5 th grade		
6 th grade		
7 th grade		
8 th grade		
9 th grade		
10 th grade		
11 th grade		
12 th grade		

Has this child/adolescent repeated any grades? Yes No

If yes, please specify which grade and why: _____

Has this child/adolescent participated in any special education or other programming? If so, indicate which grade(s) _____

Program	Grade(s)	Program	Grade(s)
Early Childhood Spec. Ed./Developmental Delay:	_____	Developmental/Cognitive Disability:	_____
Special Learning Disability:	_____	Autism Spectrum Disorder:	_____

What are this child/adolescent's strengths in school? _____

What are this child/adolescent's weaknesses in school? _____

Is the school doing a good job of meeting your child/adolescent's needs? _____

Does the child get bullied by peers at school and/or on social media platforms? _____

Has the child ever been suspended or expelled from school? _____

Has the child been arrested: _____

Is your child/adolescent currently employed? If yes, where and how many hours/week? _____

Are there any weapons or guns in your home? Yes or No _____

If yes, Does your child have access to them? _____

Has the child been tested for hearing, speech/language abnormalities? _____

Has the child ever received occupational or physical therapy? _____

Alcohol / Substance Use

Does your child or adolescent drink alcohol? Yes No

Has your child or adolescent ever experimented with drugs? Yes No

If you responded “no” to both questions, you can STOP here. Thank you for providing us with this important information.

If you responded “yes” to one or both questions, please complete the remaining questions:

CAGE-AID Questions (to be completed by a child/adolescent age 12 and up)

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Which category of mood altering substances has your child/adolescent used?

Alcohol Prescription drugs Street drugs Over-the-counter drugs None known

Please name all mood-altering substances this child/adolescent has used:

How many years altogether has this child /adolescent been drinking and/or using drugs? _____

How would you describe this child/adolescent’s pattern of alcohol or chemical use”?

Continuous and progressive On and off with no pattern A fairly regular pattern Decreasing but more destructive

Has this child/adolescent shown signs of significant mood changes? Yes No

If yes, please explain:

The following is a list of common symptoms in individuals who are abusing alcohol or drugs. Please check all that apply.

- Blackouts. How often: _____
- Minimizes the extent of their use. Describe: _____
- Lies about where they go or who they are with. When did this start? _____
- Engages in abusive or aggressive behavior. Describe: _____
- Uses mood altering drugs/medications when drinking or substitutes medications for alcohol?
- Stops drinking for periods of time. How often and why? _____
- There have been changes in this child/adolescent’s drinking pattern. Describe: _____

- This child/adolescent’s drinking and/or chemical use has resulted in changes in family activities. Describe: _____

- Unreasonable resentments. Describe: _____

- Changes in sexual drive or activity. Describe: _____
- Binges or benders. Describe: _____
- Tremors or alcohol/drug related physical problems. Describe: _____
- Narrowed range or lack of interests. Describe: _____
- Changes in the type of friends or attitudes toward friends. Describe: _____
- Left or threatened to leave home after being confronted about chemical use. Describe: _____
- Was told by a physician that chemical use is injuring his/her health. Describe: _____
- Family members have complained that this child/adolescent spends too much money on alcohol or other chemicals. Describe: _____
- Has quit or been threatened with expulsion or suspension from school due to chemical use. Describe: _____
- Has been picked up/arrested by police for intoxication or other chemical use related charges. Describe: _____
- Has had accidents/injuries related to drinking or chemical use. When/Describe: _____
- Has had illnesses related to drinking or chemical use. When/Describe: _____
- Has been gone from home without notifying parent(s). When/Describe: _____
- Has had other negative consequences related to drinking or substance use. Describe: _____

We/I feel responsible for this child/adolescent's drinking/chemical use? Yes No

We/I sometimes feel guilty about this child/adolescent's drinking/chemical use? Yes No

We/I feel this child/adolescent could quit drinking/using if he/she wanted to badly enough? Yes No

This child/adolescent simply lacks the will power to quit drinking/using? Yes No

Alcoholism is not a disease so much as it is a sin and moral problem? Yes No

We/I feel that this child/adolescent isn't alcoholic or chemically dependent but rather has a drinking/use problem? Yes No