PARENT / GUARDIAN / PRIMARY CARE GIVER PRE-ADMISSION QUESTIONNAIRE

Thank you for taking the time to answer this questionnaire honestly and thoroughly. Your answers provide our providers, nurses and therapists with a more comprehensive picture of your child. Even details about your immediate and extended family are significant in making an accurate assessment for your child, especially in regard to substance abuse, mental health, and medication use. We would like to encourage your participation in your child’s treatment and aftercare planning and recognize your partnership in care.

Please know that minors do have rights in making their own healthcare decisions. Certainly, family alignment in decision making is preferable, but there may be times when your child makes a decision independent of your wishes. Legally, your child may make certain decisions. (See Understanding Minor’s Rights form.)

Thank you, again. Please don’t hesitate to call YRC’s Admission’s coordinator @ 970-384-7484 or nursing staff @ 970-384-7473.

QUESTIONNAIRE

1.) In your opinion how has the use of drugs impacted your child’s life?

2.) In your opinion, has the use of drugs/alcohol caused any negative things to happen in your child’s life?
   If yes, please describe negative aspects in any of the following:
   - Legal Issues/Jail, Arrests – (list crimes, court experiences, time periods in Jail, etc.)

   - Family Issues/Change – (list divorce, domestic violence, death, fighting, etc.)
• *Health Issues/Medications* – (list ER visits, inpatient treatment, started or changed medications, illnesses, suicide attempts, etc.)

• *Traumatic Events/Losses* – (list death of friend/family, loss of job, divorce, rape, suicide, etc.)

• *Change in Peer/Romantic Relationships* – (list breakup, new relationship, pregnancy, loss of friend.)

• *School Issues* – (list expulsion, using in school, returned to school, etc.)

**HEALTH**

17.) Does your child have any physical limitations or disabilities? NO____YES____

If YES, what type?

18.) Does your child have any *health issues* that require frequent medical care? NO____YES____

(Ex- Asthma, Diabetes, Chronic Pain, ADHD, Depression, Anxiety, Bipolar Disorder, Hallucinations, etc.)

If YES, please name the medical condition:

19.) Are you comfortable with our providers prescribing psychiatric medications for your child? YES____ NO____ If not, why?
20.) Does your child take any prescribed medications on a daily basis? NO ___YES ___
If YES, please provide the Name/s & Dose/s of Medications, What it is treating & When was it prescribed?

Do you administer the medicine to your child?   YES___NO___

Has your child experienced any negative side effects from your medication?  NO____ If YES, please explain:

21.) Which medication/s have been helpful for your child and how?

22.) Do you or any other members of your family take prescribed medications for mental health issues? (Depression, anxiety, bipolar disorder, schizophrenia, anger)  NO___YES___
If YES, please list the reason for the medication & name the medication

Biological Mother of the child _______________________________________________________

Biological Father of the child _______________________________________________________

Full Siblings of the child _________________________________________________________

Maternal Side of the Family – list family member & medication prescribed (Ex. Half Siblings, Aunt, grandparent, etc.)
23.) Does anyone in your family have their **MEDICAL MARIJUANA** card?

NO ___ YES ___

If YES, please list the family member & explain their medical condition:

**FAMILY**

24.) Please indicate the status of your relationship with your child’s other biological parent *(Please check any that apply to you)*

LIVE TOGETHER ____ ARE SEPARATED ____ ARE DIVORCED ____

WERE NEVER MARRIED______ WE NO LONGER HAVE ANY CONTACT ______

25.) Are you remarried or living with another partner? NO ____ YES ___

If YES, for how long?

26.) How would you describe the general atmosphere of your home *(CHECK ALL THAT YOU THINK APPLY)*

Safe _____ Chaotic _____ Lots of Arguing ______ Nurturing ____ Unloving_____

Fun____ Unsafe because of Domestic Violence____ We move a lot ______

There is Drug/Alcohol Use in the Home______

Please list any immediate & extended family member **who use drugs/alcohol** & their substance of choice:
27.) Are there challenges in your home such as substance use, unemployment, and/or difficult relationships that may cause safety issues in your home?

28.) **MY CHILD’S WEAKNESSES – Please Circle All That Apply**

- Boring
- Weird
- Angry
- Loud
- Lazy
- Not Smart
- Judgmental
- Mean
- Miserable
- Liar
- Depressed
- Loner
- Anxious/Nervous
- Physically Aggressive

29.) **MY CHILD’S STRENGTHS – Please Circle All That Apply**

- Smile A Lot
- Athletic
- Friendly
- Kind
- Smart
- Generous
- Loyal
- Compassionate
- Love To Learn
- Adventurous
- Artistic
- Musical
- Passionate
- Independent
- Unique
- Helpful To Others
- Organized
- Responsible
- Self Starter
- Finish What He/She Starts