YOUTH RECOVERY CENTER

PARENT NAME: _____
CLIENT NAME: _____

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.)

YOUTH RECOVERY CENTER

- *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

3.) Does your child have any physical limitations or disabilities? NO___YES___

If YES, what type?

4.) 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:

5.) Are you comfortable with our providers prescribing psychiatric medications for your child? YES ____ NO____ If not, why?

YOUTH RECOVERY CENTER

6.) 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:

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

8.) 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.)

YOUTH RECOVERY CENTER

Paternal Side of the Family – list family member & medication prescribed (Ex. Half Siblings, Aunt, grandparent, etc.)

9.) Does anyone in your family have their ***MEDICAL MARIJUANA*** card?

NO ___YES___

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

FAMILY

10.) 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 _____

11.) Are you *remarried or living with* another partner? NO___ YES___

If YES, for how long?

12.) 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:

YOUTH RECOVERY CENTER

13.) Are there challenges in your home such as substance use, unemployment, and/or difficult relationships that may cause safety issues in your home?

14.) ***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

15.) ***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