



**YOUTH RECOVERY CENTER**

**CLIENT NAME:** \_\_\_\_\_

**CLIENT PRE-ADMISSION QUESTIONNAIRE  
FOR ADDITIONAL INFORMATION: 970.384.7484**

Welcome to the *Youth Recovery Center!* We are so pleased by your interest and future admission to our program. As part of the admission process, we ask that you take the time and consideration to answer this questionnaire; it may take you about a half an hour to complete. Please *be thorough and honest* so that we can support you in your goals for treatment. As noted below, *we keep all your information private*. If you have questions, don't hesitate to call our admission's team at 970-384-7484. We look forward to meeting you!

Please note that *the following information will be kept confidential* except in the case of unreported abuse, as stipulated by 12.43.214(1) (c) CRS.

**QUESTIONNAIRE**

- 1.) In your opinion how has the use of drugs impacted your life?
  
  
  
  
  
  
  
  
  
  
- 2.) In your opinion, has the use of drugs/alcohol caused any positive things to happen in your life?  
If yes, please describe how.
  
  
  
  
  
  
  
  
  
  
- 3.) In your opinion, has the use of drugs/alcohol caused any negative things to happen in your life?  
If yes, please describe how.
  
  
  
  
  
  
  
  
  
  
- 4.) Which drug/alcohol do you think about the most and/or use the most if it's available? (*Drug/s of Choice*) Please list:



5.) Have you experienced any of the following during your using times?

*Please check all that apply to you.*

- Need more and more to get high?
- Have cravings or a strong desire to use?
- Unable to go to work or school due to my substance use?
- Have tried to “quit” but end up using again?
- Spend a lot of time thinking about how to get the drug/alcohol and how I will pay for it?
- Spend less time in sober activities and more time w/ using friends getting high and doing activities high?
- Continue to use despite problems at home or work?
- Use and get high to deal with uncomfortable issues/feelings in my life?
- Don’t feel capable of dealing with my life without my drug/alcohol of choice?
- Put yourself in dangerous situations in order to obtain your drug
- Put yourself in dangerous situations in order to “get high”

6.) What has happened in your life **over the last 3 months** that is **now motivating you** to come to YRC for drug & alcohol treatment? Examples: loss of someone, legal costs, hospitalizations, experienced violence, suicide attempt, divorce, behind in or expelled from school, parent in prison, etc.

- *Legal Issues/Jail, Arrests* – (list crimes, court experiences, time periods in Jail, etc)
  
- *Family Issues /Changes*– (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)

7.) On a scale of 1-10 (10 means that I am 100% committed to participating in treatment at YRC. Please be honest about your motivation. We do not expect that everyone will be highly motivated at this stage!)

***Rate yourself on how motivated you feel to start treatment at YRC.***

**1 2 3 4 5 6 7 8 9 10 (Circle)**

How do you usually participate in group activities? ***Please CHECK what applies to you.***

I'm usually very quiet & observe more than I talk\_\_\_\_\_ I love to jump in and talk\_\_\_\_\_

I am usually distracting to others\_\_\_\_\_ I have a hard time staying focused \_\_\_\_\_

I am easily bored\_\_\_\_\_ I am easily annoyed by others\_\_\_\_\_ I blow up when angry\_\_\_\_\_

7.) If you could ***magically change*** anything in your life so that you could ***achieve a drug-free lifestyle, what would you change and what would your new life look like?***

- *Legal Issues/Jail, Arrests* –
- *Family Issues /Changes*–
- *Health Issues* –



- *Traumatic Events/Losses –*
- *Peer/Romantic Relationships –*
- *School Issues –*
- *Education –*

8.) On a scale of 1-10 (10 meaning that I am 100% ready and motivated to live a sober lifestyle) *rate yourself on how motivated you are to live your life drug and alcohol free (Once again, please be honest)*

**1 2 3 4 5 6 7 8 9 10** (Circle)

*Circle one or more responses to each category of drug below.*

**MARIJUANA** - I think I can use marijuana:

At a party \_\_\_ Once I'm off probation \_\_\_ When I'm 21 years old \_\_\_ I can never use it again \_\_\_

**ALCOHOL**- I think I can use alcohol:

At a party now \_\_\_ Once I'm off probation \_\_\_ Once I'm 21 years old \_\_\_ I can never use it again

**METHAMPHETAMINE/COCAINE**- I think I can use Meth/Cocaine:

If I'm smart about it I can use during probation \_\_\_ Once I'm off probation \_\_\_ I can never use it again \_\_\_



**HEROIN/OPIATES** -I think I can use Heroin/Opiates:

If I'm smart about it I can use during probation \_\_\_ Once I'm off probation \_\_\_ I can never use it again\_\_\_

**HALLUCINOGENS/ACID/MUSHROOMS/ECSTACY**-I think I can use Hallucinogens:

If I'm smart about it I can use during probation \_\_\_ Once I'm off probation\_\_\_ I can use it never again\_\_\_

**DXM/TRIPLE C'S/KETAMINE**-I think I can use:

If I'm smart about it I can use during probation \_\_\_ Once I'm off probation\_\_\_  
I can never use again\_\_\_

**BARBITURATES/XANAX/KLONIPIN/VALIUM**- I think I can use:

If I'm smart about it I can use during probation \_\_\_ Once I'm off probation \_\_\_  
I can never use again \_\_\_

9.) Please **circle all** the substances you have used in the **last six months** -

ALCOHOL    MARIJUANA    METHAMPHETAMINE    COCAINE    INHALANTS  
SPICE    HEROIN/OPIATES    ECSTACY    MUSHROOMS    DXM/TRIPLE C's  
XANAX/BARBITURATES    LSD    SALVIA    OVER THE COUNTER MEDICATIONS

Check each **month** that you used any or all of the above **circled** substances (**Go back over the last six months! For example, if the current month is July, you would review months January through July.**)

January_____	May_____	September_____
February_____	June_____	October_____
March_____	July_____	November_____
April_____	August_____	December_____



Have you ever stopped taking your *drug of choice* or used a *different substance* to avoid a **hot UA**?

NO\_\_\_ YES\_\_\_ If YES, please list any substance you used to beat your **UA's**:

## SCHOOL

10.) Are you presently attending school? NO \_\_\_ YES \_\_\_ Public \_\_\_ Alternative \_\_\_  
Online \_\_\_

11.) Have you received special education services in school? NO \_\_\_ YES \_\_\_

12.) Date (month/year) of last regular attendance in school \_\_\_\_\_

13.) Did you go to class high? NO \_\_\_ YES \_\_\_

Which substances did you use? \_\_\_\_\_

14.) Did you skip school or class to get high? NO \_\_\_ YES \_\_\_

15.) How many credits do you have towards High School Graduation? \_\_\_\_\_

16.) List the YEAR of your graduating class \_\_\_\_\_

## HEALTH

17.) Do you have any physical limitations or disabilities? NO \_\_\_ YES \_\_\_

If YES, what type? \_\_\_\_\_

18.) Do you 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 conditions: \_\_\_\_\_



19.) Do you take any prescribed medications on a daily basis? NO \_\_\_ YES \_\_\_

If YES, *names and doses of each Medication*, What is it treating? When was it prescribed?

Do you take the medicine as ordered & on time? YES\_\_\_NO\_\_\_ If NO why not? \_\_\_\_\_

Have you experienced any negative side effects from your medication? NO\_\_\_ If YES, please explain \_\_\_\_\_

Which clinician prescribed the medication for you? (Dr/ Nurse Practitioner/Clinic Name)

20.) Which medication/s have been helpful and how?

21.) Do any other members of your family take prescribed medications? NO\_\_\_ YES\_\_\_ If YES, please explain their medical condition: \_\_\_\_\_

22.) Does anyone in your family have their **MEDICAL MARIJUANA** card? NO \_\_\_ YES\_\_\_

If YES, please explain their medical condition: \_\_\_\_\_

23.) Are you pregnant? NO\_\_\_ YES\_\_\_

24.) Do you have a child OR children? NO\_\_\_ YES\_\_\_ If YES, age/s: \_\_\_\_\_

If you do have a child, do you have custody of your child? NO\_\_\_ YES\_\_\_ What is the name of person with custody? \_\_\_\_\_



## LEGAL

25.) Check the **criminal behaviors** that have caused you to be catch a charge:

\_\_\_\_ Weapons Offense    \_\_\_\_ Hot UA's    \_\_\_\_ Vandalism/Mischief  
\_\_\_\_ Theft    \_\_\_\_ Burglary    \_\_\_\_ Shoplifting    \_\_\_\_ Harassment  
  
\_\_\_\_ Assault/Violence    \_\_\_\_ Armed Robbery    \_\_\_\_ Forgery/Fraud  
\_\_\_\_ Trespassing    \_\_\_\_ DUI    \_\_\_\_ Probation Violation\_\_\_\_  
\_\_\_\_ Sales of Drugs    \_\_\_\_ Possession    \_\_\_\_ Disorderly Conduct \_\_\_\_

26.) Circle any of the above crimes that you committed either **high or intoxicated**.

27.) Name of your Probation Officer \_\_\_\_\_

28.) How old were you when you were first arrested? \_\_\_\_\_

What was the charge? \_\_\_\_\_

Please list any other arrests with the **general date of when you were arrested**

\_\_\_\_\_

29.) When is your next court date? \_\_\_\_\_ Are you facing **commitment to DYC**?  
NO\_\_\_ YES\_\_\_

30.) Are you involved in gang activity? NO\_\_\_ YES\_\_\_

If YES, which gang or "color" do you support? \_\_\_\_\_

What does the gang life provide you with?

\_\_\_\_\_

31.) Have you been involved in **cult activity**? (EX. Satanism) NO\_\_\_ YES\_\_\_

32.) Have you ever been charged with **arson**? (starting fires) NO\_\_\_ YES\_\_\_ If YES, list the date: \_\_\_\_\_





33.) Have you ever purposefully killed *an animal*? NO\_\_\_ YES\_\_\_ If YES, list the date:  
\_\_\_\_\_

34.) Have you ever been charged/convicted of a *sexual assault*? NO\_\_\_ YES\_\_\_ IF YES, list  
the date: \_\_\_\_\_

35.) Do you have a *NO CONTACT* or *RESTRAINING ORDER* with anyone? NO\_\_\_\_\_  
YES\_\_\_ If YES, Who & Why? \_\_\_\_\_

## FAMILY

36.) Do your *PARENTS*..... (Please check any that apply to you)

LIVE TOGETHER\_\_\_ ARE SEPARATED \_\_\_ ARE DIVORCED \_\_\_

WERE NEVER MARRIED\_\_\_

Do you have *FULL SIBLINGS* (names & ages)\_\_\_\_\_

37.) Are either of your *PARENTS* remarried or living with another partner? NO\_\_\_ YES\_\_\_

Do you live with your: Mom & Stepdad \_\_\_ Dad & Stepmom\_\_\_

**OR** Share time w/ both families \_\_\_\_\_

Is your relationship with your **Step Mom**: *positive*\_\_\_ *negative*\_\_\_ N/A\_\_\_ (circle one)

Is your relationship with your **Step Dad**: *positive*\_\_\_ *negative*\_\_\_ N/A\_\_\_ (circle one)

Do you have *HALF SIBLINGS*? NO\_\_\_ YES\_\_\_ IF YES, please list names & ages below:

*Mother's* children (names & ages)\_\_\_\_\_

*Father's* children (names & ages)\_\_\_\_\_

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Do you have **STEP SIBLINGS** ? NO \_\_\_ YES \_\_\_ If YES, please list names & ages below:

**Step Mom's** children (names & ages) \_\_\_\_\_

**Step Dad's** children (names & ages) \_\_\_\_\_

38.) Were you **ADOPTED**? NO \_\_\_ YES \_\_\_ If YES, How old were you when you were adopted? \_\_\_\_\_

Please name adoptive parent/s & their ages: \_\_\_\_\_

I DO \_\_\_ DON'T \_\_\_ HAVE A RELATIONSHIP WITH MY **BIRTH MOTHER**

I DO \_\_\_ DON'T \_\_\_ HAVE A RELATIONSHIP WITH MY **BIRTH FATHER**

If you do know your **birth parent/s** please explain your involvement with your birth mother or birth father (Example-time spent together)

39.) Please list the *names, ages, & relationship* of **ALL the people** who live in your home now:  
(Example-Jane, 35, mother) -

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40.) Please list the *names, ages, and relationship* of **ALL the people who DO NOT** live in your home BUT you consider them to be close or immediate family members:

(Example- Joe, 62, Grandfather)

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41.) *When I live at home, my family home can feel (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 family member who uses drugs/alcohol & their substance of choice \_\_\_\_\_

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Is your home *unsafe* for any other reasons? (Please list reasons)

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42.) What **MAJOR LOSSES** have you experienced in your life? (Example: friend-suicide, family member-overdose, loss of innocence-raped, loss of trust/betrayal-father, parents-divorced, etc.)

43.) Have you ever been exposed to or involved in the **HUMAN TRAFFICKING** business (the unwilling transportation of a person to another location for the purpose of prostitution/drug trade or sale/any other illegal activity) NO \_\_\_ YES \_\_\_ IF YES, please explain below:

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## TREATMENT EXPERIENCE

44.) Where have you gone for *OUTPATIENT DRUG/ALCOHOL TREATMENT*?

45.) Did you usually go to group high/drank? NO\_\_\_ YES\_\_\_

46.) List *ONE POSITIVE EFFECT* of treatment –

47.) List *ONE NEGATIVE EFFECT* of treatment –

## STRENGTHS/WEAKNESSES

48.) *MY WEAKNESSES* – Please circle all that apply

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

49.) *MY 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 I start