WISDOM TRADITIONS
—COUNSELING SERVICES, LLC—

PARENT/GUARDIAN QUESTIONNAIRE

ADOLESCENT SUBSTANCE USE DISORDER PROGRAM

TO HELP US BETTER SERVE YOU, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION ABOUT THE PERSON BEING ASSESSED AND BRING TO YOUR INITIAL VISIT. WHILE THE PACKET APPEARS TO BE LONG, PLEASE BE AWARE THAT IT IS MOSTLY CHECK BOXES AND TABLES. ALL INFORMATION IS CONFIDENTIAL AND WILL BE PART OF THE YOUTH'S CLINICAL RECORD. FEEL FREE TO USE ADDITIONAL PAPER IF YOU NEED MORE SPACE. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS ABOUT ANY OF THE INFORMATION REQUESTED.

IF THE YOUTH IS CURRENTLY FEELING SUICIDAL, PLEASE CALL THE CARELINE CRISIS LINE AT 1-877-266-4357, THE ANCHORAGE COMMUNITY MENTAL HEALTH HOTLINE AT (907) 563-3200, OR GO TO THE NEAREST EMERGENCY ROOM.
THANK YOU- THE WISDOM TEAM

Youth name: _____ Date of Birth: ____/_____/_____

Questionnaire completed by: _____ Relationship: _____

Referred by: _____

DEMOGRAPHICS:

Emergency Contact Name: _____ Phone Number: _____

Who are the Youth's legal guardians?

_____

_____

Is there anyone who should not have contact with the Youth?

_____

_____

_____

Who will be transporting the Youth to/from treatment?

_____

_____

Is there anyone we should have an ROI on file for? (ex. probation officer, therapist, school, etc)

_____

_____

WHAT ARE YOUR CHIEF CONCERNS REGARDING THE YOUTH?

_____

_____

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_____

SUBSTANCE USE HISTORY (TO THE BEST OF YOUR KNOWLEDGE)

Current Use (date of last use for substances used to include amounts used)

Date: ____/_____/_____ , Substance:_____Amount:_____

Date: ____/_____/_____ , Substance:_____Amount:_____

Date: ____/_____/_____ , Substance:_____Amount:_____

History of Withdrawal Symptoms: ☐No ☐Yes, Specify: _____

_____

CHEMICAL USE HISTORY (INCLUDE AGE OF FIRST USE, FREQUENCY & AMOUNTS USED)

N/A	Chemical/Substance	Age of First Use	Frequency	Amounts	Notes
☐	**Alcohol**				

☐	**Marijuana** (pot, hash, Marinol)				
☐	**Stimulants** (Cocaine, Amphetamines.)				
☐	**Narcotics/Opiates**				
☐	**Sedatives/Hypnotics**				
☐	**Hallucinogens** (LSD, Mushrooms, and Ecstasy)				
☐	**Barbiturates** (Seconal, Phenobarbital, Dalmane, Restoril)				
☐	**Inhalants** (Gas, glue, Nitrous Oxide, Solvents, etc.)				
☐	**Tobacco/ Nicotine**				
☐	**Caffeine**				
☐	**Other, specify:**				

Has the Youth had prior Substance Use Treatment?

☐ No ☐Yes, Specify: _____

MEDICAL HISTORY

Primary Physician: _____ **Specialty Provider:**_____

Medical and/or dental conditions that may complicate participation in treatment? ☐ Yes ☐ No

Reported problem(s): _____

Any allergies we should be aware of? ☐ Yes ☐ No **If so, when and what for?**

_____

Any history of head injuries or physical trauma? ☐ Yes ☐ No **If yes, when?**

_____

Loss of consciousness? ☐ Yes ☐ No Hospitalized for it? ☐ Yes ☐ No

Any prenatal exposure to drugs, tobacco, or alcohol? ☐ Yes ☐ No **If yes, describe.**

_____

Any major hospitalizations/ER visits/surgeries? ☐ Yes ☐ No **If so, when and what for?**

_____

_____

_____

Did the Youth hit their developmental milestones appropriately? ☐ Yes ☐ No **If not, describe.**

_____

_____

_____

CURRENT PRESCRIBED MEDICATIONS (NON-PSYCHIATRIC):

Medication	Dosage/Frequency	Prescriber

Does the Youth take medications as prescribed? ☐ Yes ☐ No ☐Unknown

Have you noticed any allergy/adverse reaction to meds? ☐ Yes ☐ No

NUTRITION ASSESSMENT

Have you noticed any of the following:

Current Appetite? ☐ Good ☐ Fair ☐ Poor **Past Appetite Change?** ☐ Yes ☐ No

Sudden Weight Gain or Loss ☐ Yes ☐ No **Current signs/symptoms of eating dis.** ☐ Yes ☐ No

Binge eat ☐ Yes ☐ No Self-induced vomiting ☐ Yes ☐ No

Laxatives for weight loss ☐ Yes ☐ No Diet Pills ☐ Yes ☐ No

Fasting for weight loss ☐ Yes ☐ No Prior Diagnosis ☐ Yes ☐ No

Has the Youth ever used any type of complementary health approaches like holistic, alternative or traditional treatments?

_____

_____

EMOTIONAL, BEHAVIORAL, COGNITIVE CONDITIONS

Has the Youth had prior Mental Health Treatment for depression, anxiety, bipolar, ADD/ADHD, FASD, etc?

☐ No ☐Yes, Specify: _____

Has the Youth ever been prescribed medication for mental health conditions? (such as *anti-depressants, Prozac, Paxil, Zoloft, Serzone, Effexor, Trazadone, Elavil, Cymbalta, etc. or tranquilizers, Zyprexa, Risperdal, Prolixin, Haldal, Loxitane, Thorazine, Lithium, Serequel, Abiliifiy, Celexa, Lexapro, etc and other psychotropic medications*).

CURRENT PRESCRIBED PSYCHIATRIC MEDICATIONS:

Medication	Dosage/Frequency	Prescriber

Does the Youth take as prescribed? ☐Yes ☐No ☐Unknown

SUICIDE, SELF-HARM, AND HARM TO OTHERS RISK ASSESSMENT

Has any family member ever attempted suicide? ☐ Yes ☐ No

Were they successful? ☐ Yes ☐ No

Does the Youth have a history of self-harm ☐ Yes ☐ No

Any history of suicidal ideation and/or attempts (*past, present, frequency*): ☐ Yes ☐ No

_____

Any history of homicidal ideation and/or attempts of hurting others (assault, *hx/pattern of violent acts):* ☐ Yes ☐ No

_____

OTHER ISSUES

Are there other issues you are concerned about? (*eating, gambling, sex, behavioral, addictive personality, workaholic, codependency, internet/computer, etc.*) _____

_____

_____

How much time per week does the Youth spend watching TV?_____

How much time per week does the Youth spend playing video games?_____

Any Grief or Loss issues? _____

What are the Youth's weaknesses? _____

Any other stressors we should be aware of?

_____

_____

TRAUMA SCREENING

To the best of your knowledge, has the Youth ever experienced:

Physical Abuse? ☐ Yes ☐ No

Emotional Abuse? ☐ Yes ☐ No

SexualAbuse? ☐ Yes ☐ No

Neglect? ☐ Yes ☐ No

Caregiver Substance Abuse? ☐ Yes ☐ No

Caregiver incarceration? ☐ Yes ☐ No

Removal from household? ☐ Yes ☐ No

Witness Domestic Violence? ☐ Yes ☐ No

Any other traumas we should be aware of? (ex. housefires, refugee status, organ transplant, etc.)

_____

_____

_____

_____

_____

READINESS TO CHANGE

Do you foresee any barriers to the Youth's treatment?

_____

_____

Are you ready to make changes, if necessary, to support the Youth's treatment? What is your current commitment level? _____

_____

_____

RELAPSE, CONTINUED USE, AND RISK POTENTIAL

Describe the Youth's peer group:

_____

_____

_____

_____

Has the Youth relapsed in the past? If so, what happened?

_____

_____

What current factors could lead to a relapse? _____

_____

What are the Youth's strengths?

1)_____

2)_____

3)_____

RECOVERY & LIVING ENVIRONMENT

LEGAL ASSESSMENT: *CUSTODY, OCS, GUARDIANSHIP, BANKRUPTCY, CRIMINAL, PROBATION, DUI/OUI, ETC.*

Legal Issue/Charges	Date(s)	Legal Contact/PO	ROI on File?
			☐ Yes ☐ No

			☐ Yes ☐ No
			☐ Yes ☐ No

Has the Youth ever been convicted of a sex crime and/or are they on the sex offender registry?

☐ Yes ☐ No Explain: _____

Is the Youth currently on probation? ☐ Yes ☐ No If so, what were they were charged with?

_____

_____

Is the Office of Children's Services currently involved with the Youth? ☐ Yes ☐ No

If so, to what capacity?_____

_____

_____

CURRENT LIVING ENVIRONMENT

Where does the Youth currently reside? Do they split their time between residencies?

_____

_____

_____

Who do they live with? _____

_____

Is there other chemical use in the living environment? ☐ Yes ☐ No

By whom/what**:** _____

_____

SCHOOL ASSESSMENT

Is the Youth currently enrolled in school? ☐ Yes ☐ No What Grade: _____

Where were they last/are they currently enrolled? _____

Any school related problems from chemical use? ☐ Yes ☐ No

Other behavioral problems at school? ☐ Yes ☐ No (if yes, describe below)

Has the Youth been diagnosed or suspected of any learning disabilities/difficulties with learning/ reading/writing?

☐No ☐Yes (Please specify) _____

Other information we should know about the Youth's education history: _____

_____

_____

_____

_____

_____

_____

_____

SUPPORT AND SOCIAL SYSTEMS

Who will support the Youth in recovery: (*Family, friends, significant others, sponsor, coworkers, supervisors, church, etc*):

_____
_____
_____
_____
_____

Describe your family's spiritual/ belief system: _____

_____

How does your family identify culturally? _____

_____

Does your family have any important traditions we should be aware of (subsistence activities, non-mainstream holidays, etc.)

_____

_____

FAMILY HISTORY

Family History (*family of origin; family history of substance use and/or mental health)*

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Is there any part of the family history that you would not like the Youth to be aware of at this time?

_____

_____

TREATMENT CONCERNS & PROBLEMS SUMMARY

HOW WOULD YOU RANK THE FOLLOWING LEVELS OF FUNCTIONING? (RANK 1-5 1=POOR 5=EXCELLENT)

Bio-medical	1 2 3 4 5	Financial	1 2 3 4 5
Emotional	1 2 3 4 5	Social	1 2 3 4 5
Legal	1 2 3 4 5	Spiritual	1 2 3 4 5
Family	1 2 3 4 5	Cultural	1 2 3 4 5
Marital/S.O	1 2 3 4 5	Support	1 2 3 4 5
Employment	1 2 3 4 5	Tx Acceptance	1 2 3 4 5

WHAT WOULD YOU IDENTIFY AS THE TOP THREE PROBLEMS/NEEDS?

1. _____
2. _____
3. _____

WHAT WOULD YOU IDENTIFY AS THE TOP THREE GOALS FOR TREATMENT?

1. _____
2. _____
3. _____

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

_____