



T A H O E
YOUTH & FAMILY
 S E R V I C E S
 A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

CLIENT (Youth 10-18 years)
CONFIDENTIAL QUESTIONNAIRE

To be filled out by the client (youth)

Today's Date: ____ / ____ / ____

Client #: _____

Medi-Cal # _____

PLEASE PRINT

Name: _____ Sex: M F Age: _____ DOB ____ / ____ / ____

Place of Birth: _____ SSN _____
city state

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Phone: _____ -- _____ -- _____ Cell Phone: _____ -- _____ -- _____

Can we leave a message? Home Cell Ethnicity/Race: _____

Marital Status: Single Married Divorced Widowed Partner Disability: _____

School: _____ Grade: _____

Parent / Guardian / Step / Foster PLEASE CIRCLE ONE

Mother's Name: _____ Age: _____ DOB _____

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Phone: _____ - _____ Cell Phone: _____ -- _____ - _____ Work Phone: _____ -- _____ - _____

Ethnicity/Race: _____ Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

Parent / Guardian / Step / Foster PLEASE CIRCLE ONE

Father's Name: _____ Age: _____ DOB _____

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Phone: _____ - _____ Cell Phone: _____ -- _____ - _____ Work Phone: _____ -- _____ - _____

Ethnicity/Race: _____ Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

Parent / Guardian / Step / Foster PLEASE CIRCLE ONE

Name: _____ Age: _____ DOB: _____

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Phone: ____ - ____ - ____ Cell Phone: ____ -- ____ - ____ Work Phone: ____ -- ____ - ____

Ethnicity/Race: _____ Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

If you do not live with any of the above, with whom do you live?

Name: _____ Relationship: _____

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Phone: ____ - ____ - ____ Cell Phone: ____ -- ____ - ____ Work Phone: ____ -- ____ - ____

Ethnicity/Race: _____ Marital Status: Single Married Divorced Partner Widowed

Occupation: _____ Disability: _____

Who else lives in your home?

	<u>NAME</u>	<u>AGE</u>	<u>DOB</u>	<u>DISABILITY</u>
Sisters:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Brothers:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Roommates:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Other:	_____	_____	_____	_____
	_____	_____	_____	_____

Have any of the following situations happened in your family? If so, when?

SITUATION	YEAR OCCURRED
<input type="checkbox"/> Parents' divorce	_____
<input type="checkbox"/> Custody battle	_____
<input type="checkbox"/> Death in the family (Who? _____)	_____
<input type="checkbox"/> Significant person leaving (Who? _____)	_____
<input type="checkbox"/> Arrest (Who? _____)	_____
<input type="checkbox"/> Accident or injury (Who? _____)	_____
<input type="checkbox"/> Physical or sexual assault	_____
<input type="checkbox"/> Major family illness (mental or physical)	_____
<input type="checkbox"/> Recent move	_____
<input type="checkbox"/> Parent in jail or prison (past____ present____)	_____
<input type="checkbox"/> Pregnancy, self or parent	_____
<input type="checkbox"/> Expulsion or suspension from school	_____
<input type="checkbox"/> Witnessing a crime or being a victim of one	_____
<input type="checkbox"/> Family member using drugs or alcohol (past ____ present____)	_____
<input type="checkbox"/> Adoption or Foster services	_____
<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Have you had a history of cutting or self-harm? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Have you had any suicide attempts? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Any attempts without hospitalization? Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
<input type="checkbox"/> Do you have any relatives that have had serious mental or emotional problems? Yes <input type="checkbox"/> No <input type="checkbox"/> If "yes", please list them: _____	

Are you currently seeking services from (or have you been involved with) any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Women's Center | <input type="checkbox"/> Sierra Recovery Center |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Family Resource Center | <input type="checkbox"/> Private Counselor |

Who referred you here?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> School | <input type="checkbox"/> LTUSD Expulsion Board | <input type="checkbox"/> Family |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Yourself |
| <input type="checkbox"/> SARB | <input type="checkbox"/> Sierra Recovery Center | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Women's Center | <input type="checkbox"/> Police Department | |

<i>Has anyone felt concerned about your drinking or using?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Do you feel concerned about your use?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Do most of your friends use or drink?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Have you ever overdosed on drugs or alcohol (alcohol poisoning)?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Have you ever been to the emergency room or hospital?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Has alcohol or drug use caused problems for you at school, at home, in relationships, or at your job?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

If yes, please explain. _____

Have you ever used drugs to numb uncomfortable feelings?
(boredom, sadness, anxiety, insomnia/sleeplessness) Yes No

Have you ever received outpatient treatment for drugs or alcohol use? Yes No

If yes, when and where? (include TYFS outpatient, TREC, and SAP Program in Juvenile Hall) _____

Has any family member received treatment for drug(s) or alcohol use? Yes No

If yes, when and where? _____

Have you ever used any of the following? Please be honest. THIS IS CONFIDENTIAL

- | | | | | |
|--|------------------------------|-----------------------------|---------------------------|------------------------|
| Alcohol | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Marijuana | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Spice | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Hallucinogens (LSD, mushrooms, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Cocaine | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Crack (Ice) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Methamphetamines (crank, speed) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Ecstasy (E) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Pills
(codeine, oxycotin, vicodin, soma, valium, xanax, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Inhalants, nitrous oxide | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Heroin, morphine, methadone | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Over the counter medication | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How many times? _____ | Age first tried: _____ |
| Do you regularly smoke cigarettes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How much/how often? _____ | Age first tried: _____ |
| Would you like help to quit? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | |

Please check all the behaviors or symptoms that you have experienced.

Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Sneaking out & staying out all night before the age of 13
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	Running away (how many times? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Truant from school before age 13
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Expressing severe disgust in others
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Having nightmares or flashbacks about being abused
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating patterns	<input type="checkbox"/>	<input type="checkbox"/>	Increase in aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Major increase or decrease in interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Anger, rage or fear towards certain people
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Lack of caring about anything	<input type="checkbox"/>	<input type="checkbox"/>	Baby talk
<input type="checkbox"/>	<input type="checkbox"/>	Isolation and/or trouble making or keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt If yes, when _____	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Problems with other significant person
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worrying	<input type="checkbox"/>	<input type="checkbox"/>	Academic problems
<input type="checkbox"/>	<input type="checkbox"/>	Confused thinking or mind "going blank"	<input type="checkbox"/>	<input type="checkbox"/>	Attraction to the same sex
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding certain situations or people	<input type="checkbox"/>	<input type="checkbox"/>	Problems adapting from old culture to new
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Poor body image	<input type="checkbox"/>	<input type="checkbox"/>	Change in friends
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Drop in grades and/or extended absences or tardies
<input type="checkbox"/>	<input type="checkbox"/>	Eating very little or fasting	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-image ("I'm a loser")
<input type="checkbox"/>	<input type="checkbox"/>	Exercising frequently	<input type="checkbox"/>	<input type="checkbox"/>	Low energy, sleeping more
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from family and close friends
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting after eating	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Being "hyper"	<input type="checkbox"/>	<input type="checkbox"/>	Head injury (Date: ____/____/____)
<input type="checkbox"/>	<input type="checkbox"/>	Having difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	<input type="checkbox"/>	Being fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	<input type="checkbox"/>	Reading or learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Problems getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Losing temper often	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Arguing with adults and/or refusing to obey authority figures	<input type="checkbox"/>	<input type="checkbox"/>	Feeling numb or detached ("in a daze" or "out of it")
<input type="checkbox"/>	<input type="checkbox"/>	Blaming others for your mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	<input type="checkbox"/>	Being overly sensitive, "touchy", vindictive	<input type="checkbox"/>	<input type="checkbox"/>	Unable to remember or recall certain events
<input type="checkbox"/>	<input type="checkbox"/>	Initiating fights	<input type="checkbox"/>	<input type="checkbox"/>	Having access to guns or weapons
<input type="checkbox"/>	<input type="checkbox"/>	Being cruel to animals or people	<input type="checkbox"/>	<input type="checkbox"/>	Stealing things
<input type="checkbox"/>	<input type="checkbox"/>	Deliberately setting fire to or destroying other's property	<input type="checkbox"/>	<input type="checkbox"/>	Lying, manipulating, or "conning"

Have you ever been arrested? Yes No Date _____ *In the last 24 months?* Yes No

How old were you when you were first arrested, and what were you arrested for? _____

Are you currently on probation? Yes No *Is this your first time?* Yes No

Have you ever been under the influence of drugs or alcohol? Yes No

What situation or problem leads you to ask for our services now? _____
