

CHANGES

SUBSTANCE ABUSE PROGRAM

In order for our therapist to understand your teen/pre-teen and your areas of concern, please complete this form. If there are questions you do not feel comfortable answering at this time, please skip them for now and you can discuss them with your therapist during your screening session. Also skip questions that are not applicable to your teen, pre-teen, and/or family.

Teen/Pre-Teen's Family of Origin History:

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother:

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father:

Names and ages of siblings _____

PROBLEMS THAT YOUR TEEN/PRE-TEEN IS HAVING

Please use a checkmark to indicate which of the following problems apply to your child:

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parent-child conflict (self) |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Parent-child conflict (spouse) |
| <input type="checkbox"/> Suicidal actions | <input type="checkbox"/> Marital/relationship problems |
| <input type="checkbox"/> Anxiety/Fears/Worries | <input type="checkbox"/> Brother/sister problems |
| <input type="checkbox"/> Anger temper problems | <input type="checkbox"/> Violence in the family (actual or threatened) |
| <input type="checkbox"/> Alcohol/other drug abuse (self) | <input type="checkbox"/> Communication problems |
| <input type="checkbox"/> Alcohol/other drug abuse (family) | <input type="checkbox"/> Sexual problem |
| <input type="checkbox"/> Job/school problems | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Major losses/difficult changes | <input type="checkbox"/> Compulsive behavior |

ANY PROBLEMS WITH COPING

Please use a checkmark to indicate which of the following problems apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> gaining weight (how much _____) |
| <input type="checkbox"/> waking up in middle of the night | <input type="checkbox"/> losing weight (how much _____) |
| <input type="checkbox"/> waking up too early | <input type="checkbox"/> not hungry |
| <input type="checkbox"/> sleeping too much | <input type="checkbox"/> vomiting after eating |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> nauseated |
| <input type="checkbox"/> Moody or crying more than usual | <input type="checkbox"/> Constipation or diarrhea |
| <input type="checkbox"/> Feeling guilty, worthless, or hopeless | <input type="checkbox"/> Difficulties concentrating |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Problem remembering things |
| <input type="checkbox"/> Hyper/too much energy | <input type="checkbox"/> Withdrawing from others |
| <input type="checkbox"/> Loss of interest in things | <input type="checkbox"/> Repeated actions that they can't stop |
| <input type="checkbox"/> Disturbing thoughts that they can't stop | <input type="checkbox"/> Cannot stop washing hands, body, counting or checking things |
| <input type="checkbox"/> People are out to get me | |
| <input type="checkbox"/> People are picking on me | |

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MEDICAL HISTORY

Please use a checkmark to indicate any of the following medical conditions that the person being screened has currently or has had in the past.

Asthma Diabetes Ulcers Migraines Epilepsy Seizures Lupus Stroke Cancer

Heart Condition Multiple Sclerosis Headache Previous Head Injury Thyroid Problem

Gynecological Problems Other (Specify): _____

Drug Allergies; if yes, which drugs _____

Previous Hospitalizations/Surgeries (Please list dates and reasons)

Previous Suicide Attempts (Please list dates and methods). If none, write "none". _____

Current or Past Health Problems _____

Current Prescriptions/Medications (Please list all prescription medication, OTC and herbal supplements)

Prescribing Physician _____

Family History (Please list any major familial health problems, drug or alcohol use)

PREVIOUS COUNSELING

Has your teen/pre-teen been in counseling previously? Yes No (If yes, please list dates and the focus of the sessions and reason counseling was terminated)

Has any member of your family been treated for the following?

Schizophrenia Yes No If yes, who? _____

Bipolar Disorder Yes No If yes, who? _____

Major Depression Yes No If yes, who? _____

Substance Abuse Yes No If yes, who? _____

FAMILY LIFESTYLE CHOICES

Do you smoke? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you use other types of drugs? Yes No If yes, how much? _____

Do you have any weapons in your home? Yes No If yes, what type: _____

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ANYTHING ELSE YOU WANT US TO KNOW?

Parent/Guardian's Name _____ Date _____

SUBSTANCE USE SCREENING

What substances are you concerned about your teen using? _____

List substance(s) name and length of time of suspected use _____

What evidence do you have about your teens substance use? _____

PREVIOUS HELP FOR SUBSTANCE ABUSE

Have you ever sought help before for substance abuse? No Yes

If yes, complete the following

Person/Program Name _____ Year _____

Did you find this helpful? No Yes

Please explain: _____

FAMILY HISTORY OF SUBSTANCE USE

Are there current or a past family history of alcohol or drug problems? No Yes

Please explain _____

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Please check kind of school problems have your teen has had?

- a. None
- b. Suspension (How many? __)
- c. Expulsion
- d. poor grades
- e. attendance board
- f. detention

Do you think any of these problems are related to the use of alcohol or other drugs? No Yes

Explain: _____

LEGAL

Does your teen have any current legal problems, including pending court cases? No Yes

Explain: _____

LEARNING

1. What is your teen's preferred method of learning?: Visual Auditory Written

2. Primary language spoken in family: _____

STRUCTURE

What efforts have been attempted by adults to limit or stop substance use by your teen?

