Counseling&Recovery
SERVICES OF OKLAHOMA
Certified Sanctuary Community

Steps of Intake

- Filling out business paperwork
- 2 hour assessment and 1 hour treatment plan with therapist
- First time doctors visit, if wish to receive medication

Client will ***NOT*** be able to schedule a doctor's appointment or receive medication until steps above have been completed.

Please make sure to fill each page out completely

Child Outpatient Information Sheet

Client Name: _____ Date: _____/_____/_____

Age: _____ Sex:_____ Race: _____

Birthdate: _____/_____/_____ Social Security Number: _____-_____-_____

Client Address: _____

City: _____ State:_____ Zip: _____

Guardian's Phone Number: (____)-_____-_____

Is this a cell phone? YES NO Can we text you? YES NO

E-mail address: _____

Guardians Name: _____

Are you the legal guardian? YES NO

If NO, who is? Name:_____ Phone Number:(____)-_____-_____

Insurance Insurance Medicaid Medicare Self-Pay

Member ID/Policy Number: _____

Primary Care Physician

Name: _____ Medical Center: _____

Phone Number: (____)-_____-_____ Fax Number: (____)-_____-_____

Address: _____

City: _____ State:_____ Zip: _____

Emergency Contact Information

Name: _____

Phone Number: (____)-_____-_____ Relationship: _____

Address: _____

City: _____ State:_____ Zip: _____

Was child a previous client? YES NO When was child seen here: _____ to _____

Is child currently having suicidal thoughts? YES NO

Is child currently having homicidal thoughts? YES NO

Previous suicidal/homicidal thoughts? YES NO

Number of attempts: _____ Date of Most Recent Attempt: _____/_____/_____

How: _____

Counseling&Recovery SERVICES OF OKLAHOMA
Certified Sanctuary Community

Well/**CHILD**

Child/Youth Health Risk Appraisal

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Location: _____

Client Medicaid Member ID: _____

Who is completing this form? ☐Self ☐Parent/Guardian ☐Other: _____

1. Do you have any concerns about your child's general health, development or behavior?
   ☐ Yes ☐ No
2. Does your child/youth have any of the following medical conditions?
   ☐Asthma ☐Diabetes ☐Seizure Disorder
   ☐Heart Disease ☐High Cholesterol ☐High Blood Pressure
   Please list any other physical health condition (including surgeries) that you feel is important for us to know: _____
   _____
3. Does your child need any of the following:

Primary Care Physician	☐Has	☐Need	**Eye Doctor**	☐Has	☐Need
Dentist	☐Has	☐Need	**Audiologist**	☐Has	☐Need
Medical Equipment	☐Has	☐Need	**Other Specialist**	☐Has	☐Need

PCP Name and Telephone Number: _____

Specialist Name and Telephone Number: _____

Any other healthcare providers: _____

4. Has your child had a **physical examination** in the last 12 months? ☐Yes ☐ No ☐ Unknown
5. Has your child had an **eye exam** in the last 12 months? ☐Yes ☐ No ☐ Unknown
6. Has your child had a **dental exam** in the last 12 months? ☐Yes ☐ No ☐ Unknown
7. Does your child have any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)? ☐Yes ☐ No ☐ Unknown

Client ID: _____ Client Name: _____

Child/Youth Health Risk Appraisal

8. Does your child have any allergies (food, medication, latex, etc.)? ☐Yes ☐ No ☐ Unknown
9. Does your child take any medications? ☐ Yes ☐ No

If yes, please list. Include vitamins, supplements, and over-the-counters (daily or occasional)

_____

_____

_____

_____

10. In the last 12 months has your child experienced any difficulty with wheezing or excessive night coughing? ☐Yes ☐No ☐Unknown
11. In the last 12 months, has your child experienced any noticeable weight loss or weight gain, or excessive thirst or urination? ☐ Yes ☐No ☐Unknown
12. Does your child use any special medical equipment in the home? ☐Yes ☐No
13. Does your child use any mobility tools to help him/her walk/move? ☐Yes ☐No
14. Has your child been to an Emergency Room within the last 3 months? ☐Yes ☐No

If yes, where and what reason?_____

15. Has your child been **admitted to the hospital** in the last 3 months? ☐Yes ☐No

If yes, where and what were the reasons?_____

16. Does your child see more than one doctor? ☐Yes ☐No

If yes, please list: _____

17. Does your child need immunizations? ☐Yes ☐No ☐Unknown
18. Has your child had a lead screen? ☐Yes ☐ No ☐Unknown

Client ID: _____ Client Name: _____

Counseling&Recovery SERVICES OF OKLAHOMA
Certified Sanctuary Community

Well/**CHILD**

Child/Youth Health Risk Appraisal

19. Is your child around cigarettes/cigars/pipes on a regular basis? ☐ Yes ☐ No
20. Is your child around drugs and alcohol on a regular basis? ☐ Yes ☐ No
21. How many hours of sleep does your child usually get each night? _____ hours
22. Does your child snore? ☐Yes ☐ No
23. Does your child mouth breathe? ☐Yes ☐ No
24. How many **days** per week does your child usually get exercise? _____ days
25. How many **hours** per day does your child usually get exercise? _____ hours
26. How many hours of screen time (computer/smart phone/tablet/gaming systems/television) does your child have a day? _____ hours
27. On a typical day, how many servings of fruits and/or vegetables does your child eat? (1 serving= 1 cup fresh or ½ cup cooked vegetables) _____ servings per day
28. Does your child drink plenty of water every day? ☐ Yes ☐ No
29. How many sodas or energy drinks does your child drink in a day? _____ drinks
30. Is your child sexually active? ☐ Yes ☐ No
31. Does your child take a multivitamin? ☐ Yes ☐ No
32. Does your child put on sunscreen before spending extended time outside? ☐ Yes ☐ No
33. Does your child always fasten his/her seatbelt when in a car? ☐ Yes ☐ No
34. In general, would you say your child's physical health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

_____ _____

Signature of person completing form Date

Client ID: _____ Client Name: _____

Chestnut Health Systems

GAIN
GLOBAL APPRAISAL OF INDIVIDUAL NEEDS
Coordinating Center

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver.4.0.1

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people.	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0

2h. When was the **last** time, if ever, you were treated for a mental, emotional, behavioral or psychological problem by a mental health specialist or in an emergency room, hospital or outpatient mental health facility, or with prescribed medication?	4	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

SDScr 3. **When was the last time that...**

a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0
f. you received treatment, counseling, medication, case management or aftercare for your use of alcohol or **any other drug**? Please do not include any emergency room visits, detoxification, self-help or recovery programs	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	0
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0
f. were involved in the criminal justice system, such as jail or prison, detention, probation, parole, house arrest or electronic monitoring?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

6a. Which races, ethnicities, nationalities or tribes best describe you? (Any others?) (**Please record and select all that apply**)

v1. _____

_____

Please select at least one race.

	MENTIONED Yes	No
1. Alaskan Native **(Please record tribe in 6a1)**	1	0
2. Asian	1	0
3. African American/Black	1	0
4. Caucasian/White	1	0
5. Hispanic, Latino or Chicano	1	0
a. Puerto Rican	1	0
b. Mexican	1	0
c. Cuban	1	0
e. Dominican	1	0
f. Other Central American	1	0
g. Other South American	1	0
z. Other **(Please record tribe in 6a1)**	1	0
6. Native American **(Please record tribe in 6a1)**	1	0
7. Native Hawaiin	1	0
8. Pacific Islander	1	0
99. Some other group **(Please record tribe in 6a1)**	1	0

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only
8. Site ID: _____ Site name v. _____
9. Staff ID: _____ Staff name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered
13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____
15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

GAD-7 Anxiety

Pre: _____ Mid: _____Post: _____

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "X" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Column totals:	___ +	___ +	___ +	___

= *Total Score* _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Clinician: _____

Client ID: _____ Client Name: _____

PHQ-9 Depression

Pre: _____ Mid: _____Post: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? ***(Use "X" to indicate your answer"***	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....……	0	1	2	3
2. Feeling down, depressed, or hopeless.……..……	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....……..……..	0	1	2	3
4. Feeling tired or having little energy.....……...……	0	1	2	3
5. Poor appetite or overeating.....……	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down……..	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television……..	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....……..	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....……	0	1	2	3

Column totals ___ + ___ + _____ + ___

= *Total Score* _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Clinician: _____

Client ID: _____ Client Name: _____

COMMUNICABLE DISEASE INFORMATION

COUNSELING AND RECOVERY SERVICES OF OKLAHOMA is committed to identifying and addressing needs of the client beyond the emotional. Often other health issues may affect a client.

Would you like referrals for services for the **testing of communicable diseases** (to include but not limited to HIV, AIDS, STDs, Hepatitis C, Tuberculosis)?

For yourself/client □ YES □ NO Your Initial _____
For your partner □ YES □ NO □ Not Applicable Your Initial _____
For a family member □ YES □ NO □ Not Applicable Your Initial _____

FOR OFFICE STAFF USE ONLY

If yes, **staff** will list referral agencies that will provide testing services

._____

_____

Would you like **education to be provided about** any of the above **communicable diseases**(to include but not limited to HIV, AIDS, STDs, Hepatitis C, Tuberculosis)?

For yourself/client □ YES □ NO Your Initial _____
For your partner □ YES □ NO □ Not Applicable Your Initial _____
For a family member □ YES □ NO □ Not Applicable Your Initial _____

FOR OFFICE STAFF USE ONLY

If yes, **staff** will list referral agencies that will provide education.

_____

_____

Would you like **counseling** to be provided **about how to cope with** having any of the above **communicable diseases** (to include but not limited to HIV, AIDS, STDs, Hepatitis C, Tuberculosis)?

For yourself/client □ YES □ NO Your Initial _____
For your partner □ YES □ NO □ Not Applicable Your Initial _____
For a family member □ YES □ NO □ Not Applicable Your Initial _____

FOR OFFICE STAFF USE ONLY

If yes, **assessment clinician** will enter how this will be accomplished – either at this agency or provide referral to agencies in the community.

_____

_____

SIGNATURE OF THE PERSON COMPLETING THIS FORM:_____
DATE:_____

Oklahoma Systems of Care
Baseline Risk Factors

to be completed by workers as part of baseline assessment for children, youth, and young adults aged 0 through 25

Site: _____ Date: ____/____/____

Youth Name: _____ SOC ID: _____

Child / Youth / Young Adult Risk Factors (*please check all that apply*)

- ☐ Runaway / leaving home without permission
- ☐ Withdrawal from family, social activities
- ☐ Recent dramatic changes in eating habits, sleep pattern, and/or body weight
- ☐ Age or developmentally inappropriate bed-wetting and/or soiling
- ☐ Inappropriate sexual behavior
- ☐ Perpetrator of sexual abuse
- ☐ Victim of sexual abuse
- ☐ Victim of physical abuse
- ☐ Use or abuse of alcohol and/or drugs
- ☐ Attempted suicide or suicidal thoughts
- ☐ Hallucinations – aural, visual, or tactical
- ☐ History of inpatient psychiatric hospitalization(s)
- ☐ Chronic illness
- ☐ Self-harming behavior
- ☐ Repeated incidents of lying, stealing, and/or property destruction
- ☐ Physical aggression toward authority figures, family members and/or peers
- ☐ Intentionally hurting others
- ☐ Intentionally hurting animals
- ☐ Sets fires
- ☐ Involvement in criminal activity
- ☐ Declining school grades, truancy, poor attendance
- ☐ School suspensions / expulsions
- ☐ Developmental delays
- ☐ History of neglect

Caregiver / Family Risk Factors

- ☐ Chronic physical illness in family
- ☐ Family history of mental illness, psychiatric hospitalization and/or substance abuse
- ☐ Suicide attempts
- ☐ Victim of physical abuse (other than child/youth)
- ☐ Victim of sexual abuse (other than child/youth)
- ☐ Parental incarcerations
- ☐ History of domestic violence
- ☐ Poverty
- ☐ Other children in foster care
- ☐ Child/youth exposed to substance use/abuse in the home.

Enter data at: systemsofcare.ou.edu. If you have questions, please email the E-TEAM YIS Help Desk at yis.eteam@ou.edu.

Oklahoma Systems of Care Assessment
Youth Version
to be completed by youth aged 9 through 15

Staff Name:_____ Staff Phone #: _____

Site:_____ Assessment Date:____/____/____

Youth Name:_____ SOC ID:_____

Assessment Type: ☐ Baseline ☐ 3-Month ☐ 6-Month ☐ 12-Month
☐ 18-Month ☐ 24-month ☐ 30-Month ☐ 36-Month ☐ Exit

Youth Problem Scale (Copyright © January 2000, Benjamin M. Ogles & Southern Consortium for Children) **Instructions:** Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers, parents, or employers ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school, classes, or work	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5
TOTALS						
TOTAL						

Problems Score of 25 and above = *Critical Impairment*

Youth Functioning Scale

Instructions: Please rate the degree to which your problems affect your current ability in everyday activities. Consider your current level of functioning.

	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal, employer)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4
TOTALS					
				TOTAL	

Functioning Score of 44 and below = *Critical Impairment*

Hopefulness Scale

1. Overall, how satisfied are you with your life right now?
   - 6 Extremely satisfied
   - 5 Moderately satisfied
   - 4 Somewhat satisfied
   - 3 Somewhat dissatisfied
   - 2 Moderately dissatisfied
   - 1 Extremely dissatisfied
2. How energetic and healthy do you feel right now?
   - 6 Extremely energetic and healthy
   - 5 Moderately energetic and healthy
   - 4 Somewhat energetic and healthy
   - 3 Somewhat unenergetic and unhealthy
   - 2 Moderately unenergetic and unhealthy
   - 1 Extremely unenergetic and unhealthy
3. How much stress or pressure is in your life right now?
   - 6 Very Little
   - 5 Some
   - 4 Quite a bit
   - 3 A moderate amount
   - 2 A great deal
   - 1 Unbearable amounts
4. How optimistic are you about your future right now?
   - 6 The future looks very bright.
   - 5 The future looks somewhat bright.
   - 4 The future looks ok.
   - 3 The future looks both good and bad.
   - 2 The future looks bad.
   - 1 The future looks very bad.

Family Assessment

Please tell us how well each statement below describes your family (on a scale from 0 to 5).	**Not at all like my family**					**Very much like my family**
1. My family spends too much time arguing.	0	1	2	3	4	5
2. We don't know how to work problems out.	0	1	2	3	4	5
3. I don't feel safe in my home.	0	1	2	3	4	5
4. It is hard to know what the rules are in my family.	0	1	2	3	4	5
5. We don't trust each other.	0	1	2	3	4	5
6. You can't say what you really think in my family.	0	1	2	3	4	5
7. My family is there for me.	0	1	2	3	4	5
8. I never know what to expect from my family.	0	1	2	3	4	5
9. It's ok to talk about my feelings with my family.	0	1	2	3	4	5
10. My family doesn't spend enough time having fun.	0	1	2	3	4	5

Oklahoma Systems of Care Assessment
Caregiver Version
to be completed by caregivers of children, youth, and young adults aged 5 through 25

Staff Name:_____ Staff Phone #: _____

Site:_____ Assessment Date:____/____/____

Youth Name:_____ SOC ID:_____

Completed by: ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father
☐ Foster Parent ☐ Sibling ☐ Aunt / Uncle ☐ Grandparent
☐ Other _____

Assessment Type: ☐ Baseline ☐ 3-Month ☐ 6-Month ☐ 12-Month
☐ 18-Month ☐ 24-month ☐ 30-Month ☐ 36-Month ☐ Exit

Youth Problem Scale (Copyright © January 2000, Benjamin M. Ogles & Southern Consortium for Children) **Instructions:** Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers, parents, or employers ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school, classes, or work	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5
TOTALS						
TOTAL						

Problems Score of 25 and above = *Critical Impairment*

Youth Functioning Scale

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.

	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal, employer)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4
TOTALS					
				TOTAL	

Functioning Score of 44 and below = *Critical Impairment*

Hopefulness Scale

1. Overall, how satisfied are you with your relationship with your child right now?
   - 6 Extremely satisfied
   - 5 Moderately satisfied
   - 4 Somewhat satisfied
   - 3 Somewhat dissatisfied
   - 2 Moderately dissatisfied
   - 1 Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
   - 6 Extremely capable
   - 5 Moderately capable
   - 4 Somewhat capable
   - 3 Somewhat incapable
   - 2 Moderately incapable
   - 1 Extremely incapable
3. How much stress or pressure is in your life right now?
   - 6 Very Little
   - 5 Some
   - 4 Quite a bit
   - 3 A moderate amount
   - 2 A great deal
   - 1 Unbearable amounts
4. How optimistic are you about your child's future right now?
   - 6 The future looks very bright.
   - 5 The future looks somewhat bright.
   - 4 The future looks ok.
   - 3 The future looks both good and bad.
   - 2 The future looks bad.
   - 1 The future looks very bad.

Family Assessment

Please tell us how well each statement below describes your family (on a scale from 0 to 5).		**Not at all like my family**	←				**Very much like my family**
1.	My family spends too much time arguing.	0	1	2	3	4	5
2.	We don't know how to work problems out.	0	1	2	3	4	5
3.	I don't feel safe in my home.	0	1	2	3	4	5
4.	It is hard to know what the rules are in my family.	0	1	2	3	4	5
5.	We don't trust each other.	0	1	2	3	4	5
6.	You can't say what you really think in my family.	0	1	2	3	4	5
7.	My family is there for me.	0	1	2	3	4	5
8.	I never know what to expect from my family.	0	1	2	3	4	5
9.	It's ok to talk about my feelings with my family.	0	1	2	3	4	5
10.	My family doesn't spend enough time having fun.	0	1	2	3	4	5