*the*
*Chickasaw Nation*
**Aalhakoffichi` - A Place for Healing**
**Adolescent Transitional Living Center**
111 Arrowhead Drive / Pauls Valley, Oklahoma 73075 / (405) 331-2300 / Fax (405) 331-2302

***Bill Anoatubby***
***Governor***

# APPLICATION

# FOR

_____

*Name*

*the*
***Chickasaw Nation***
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111 Arrowhead Drive / Pauls Valley, Oklahoma 73075 / (405) 331-2300 / Fax (405) 331-2302

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Dear Parent or Legal Guardian:

Enclosed is an application for admission to Aalhakoffichi'. Please complete and sign each page and return it to us as soon as possible. Each of the items listed must be received to complete this application. Adolescents cannot be considered for admission without these items:

Copy of your adolescent's:

1. Certificate of Degree of Indian Blood or tribal letter
2. Up-to-date immunization record
3. Birth certificate
4. Social Security card
5. School transcript or most current grades
6. Private insurance, Medicaid or SoonerCare insurance card
7. Current contact list

**PLEASE NOTIFY US IMMEDIATELY OF ALL ADDRESS AND PHONE NUMBER CHANGES**

Sincerely,

Cindy Maynard, LMFT
Program director

Enclosure: Application

**All forms must be completely filled out and notarized before your application can be considered for admission.**

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# APPLICATION FOR ADMISSION

☐ **Returning (if returning resident)** ☐ **New**

Name of adolescent: _____ Grade: _____

Gender: ☐ Male ☐ Female Birth date: _____ Social Security no.: _____

Affiliated Indian tribe(s): _____ Degree: _____

Church preference: _____ Can student attend another church? ☐ Yes ☐ No

Name and address of parent or legal guardian: _____

_____

Home phone: _____ Work phone: _____

Directions to your home: _____

_____

Name and phone number of neighbor, friend or relative: _____

_____

Has adolescent ever lived in a transitional living facility before? ☐ Yes ☐ No

If so, where? _____

Does the adolescent want to come? ☐ Yes ☐ No If no, please explain: _____

Reason for referral: _____

_____

*(Please put any additional information on back of page.)*

Names of brothers and sisters:

1. _____ ☐ Male ☐ Female Age: ____
2. _____ ☐ Male ☐ Female Age: ____
3. _____ ☐ Male ☐ Female Age: ____
4. _____ ☐ Male ☐ Female Age: ____
5. _____ ☐ Male ☐ Female Age: ____

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Please ***initial*** one or more of the items below if you wish to give your adolescent permission to leave the Aalhakoffichi' campus without the sponsorship of the Aalhakoffichi' facility.

1. ____ Resident is to leave *only* with written permission each time from parent/legal guardian.

2. ____ Resident is to leave campus *only* with parent or legal guardian.

3. ____ Resident is to leave campus with authorized persons listed below: MUST be over 21 years of age.

4. ____ To add other names to the check-out list, a parent/legal guardian must submit a signed permission statement through fax, letter or in person to the director 48 hours prior to resident check-out.

(1) _____ (3) _____

(2) _____ (4) _____

I, _____, am legally responsible for _____ and understand that Aalhakoffichi' is released of responsibility whenever the adolescent is checked out by authorized persons.

Aalhakoffichi' may request additional information before the adolescent is enrolled.

_____ _____
Signature of parent/legal guardian Date

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# FAMILY AND INSURANCE INFORMATION

**Person filling out form: ☐ Parent ☐ Legal guardian**

Father: _____

Age: ____ ☐ Living ☐ Deceased

Address: _____

_____
City State ZIP

Phone: Home: _____
Work: _____
Emergency: _____

Tribal affiliation: _____

Dominant language spoken in the home: ____

_____

Home agency: _____

Do you have Medicaid (SoonerCare)?
☐ Yes ☐ No If yes, what is the Medicaid number/person code? _____

Do you have private/group health insurance?
☐ Yes ☐ No If yes, please provide the insurance company's name and address:

Name of insured: _____

Relationship to adolescent: (please check one)
☐ Parent ☐ Legal guardian

What is the policy ID or Social Security no.?

_____

Group name/group number: _____

Father's known allergies: _____

_____

Mother: _____

Maiden name: _____

Age: ____ ☐ Living ☐ Deceased

Address: _____

_____
City State ZIP

Phone: Home: _____
Work: _____
Emergency: _____

Tribal affiliation: _____

Dominant language spoken in the home: ____

_____

Home agency: _____

Do you have Medicaid (SoonerCare)?
☐ Yes ☐ No If yes, what is the Medicaid number/person code? _____

Do you have private/group health insurance?
☐ Yes ☐ No If yes, please provide the insurance company's name and address:

Name of insured: _____

Relationship to adolescent: (please check one)
☐ Parent ☐ Legal guardian

What is the policy ID or Social Security no.?

_____

Group name/group number: _____

Mother's known allergies: _____

_____

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# CONSENT FORM

Adolescent's name: _____
Last First MI

Street: _____ City: _____ State: _____ ZIP: _____

Gender: ☐ Male ☐ Female DOB: _____ SSN: _____ Age: _____

Email address: _____

Emergency contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____

***Primary insurance:***

☐ Medicaid Medicaid #: _____ Renewal date: _____

*Please give receptionist your card to copy.*

☐ Private insurance Policy holder's name: _____ Group no.: _____

Insurance ID no.: _____ Phone: _____

Address, if different than client: _____

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

DATE: _____ SIGNATURE: _____

I hereby authorize the Family Resource System - Ada to apply benefits on my behalf for covered services. I request that payment from my insurance company be made directly to the Family Resource System - Ada (or to the party that accepts the assignment).

I certify that the information I have reported regarding my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

DATE: _____ PARENT/LEGAL GUARDIAN SIGNATURE: _____

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**For office use only:**
Chickasaw Nation Medical Record no:
_____
Other: _____
_____

Aalhakoffichi` applicant:

Name: _____
Last First Middle

_____ _____ _____ _____
Birth date Gender Parent/legal guardian name Home phone

PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY AND ACCURATELY. ASK ABOUT ANY QUESTION YOU DO NOT UNDERSTAND. IF MORE SPACE IS NEEDED, SHOW NUMBER AND EXPLAIN ON BACK OF SHEET.

1. Is the adolescent being treated by a doctor now? ☐ YES ☐ NO
   If yes, explain: _____

2. Has the adolescent ever had any serious illness, been hospitalized or had any medical treatments, tests or surgeries? ☐ YES ☐ NO
   If yes, explain: _____

3. Is the adolescent taking any medications (including over-the-counter, herbal, birth control, etc.) now? ☐ YES ☐ NO
   In the past year? ☐ YES ☐ NO
   If yes, explain: _____

4. Has the adolescent ever had any of the following conditions? Explain below and give date or age.

| | YES | NO | Dt/Age | | YES | NO | Dt/Age | | YES | NO | Dt/Age |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Respiratory disease | ☐ | ☐ | | 8. Anemia | ☐ | ☐ | | 15. Arthritis | ☐ | ☐ | |
| 2. Heart problems or disease | ☐ | ☐ | | 9. Asthma | ☐ | ☐ | | 16. Epilepsy | ☐ | ☐ | |
| 3. Heart murmur | ☐ | ☐ | | 10. Allergies/sinus | ☐ | ☐ | | 17. STDs | ☐ | ☐ | |
| 4. High blood pressure | ☐ | ☐ | | 11. Tuberculosis | ☐ | ☐ | | 18. Kidney disorders | ☐ | ☐ | |
| 5. Stroke | ☐ | ☐ | | 12. Hepatitis | ☐ | ☐ | | 19. Circulation problems | ☐ | ☐ | |
| 6. Rheumatic fever | ☐ | ☐ | | 13. Jaundice | ☐ | ☐ | | 20. Skin disorders | ☐ | ☐ | |
| 7. Diabetes | ☐ | ☐ | | 14. Liver disease | ☐ | ☐ | | 21. Stomach disorders | ☐ | ☐ | |

5. Is the adolescent allergic to any drug or medicine of any kind – such as penicillin, codeine, novocain, lidocaine, etc.? ☐ YES ☐ NO
   If yes, explain: _____

6. Is the adolescent allergic to anything (including food, insect stings, pollen, etc.) resulting in swelling, hives, asthma, etc.? ☐ YES ☐ NO
   If yes, explain: _____

7. Has the adolescent ever had excessive bleeding that required treatment? ☐ YES ☐ NO
   If yes, explain: _____

8. Has the adolescent ever had a blood transfusion or blood products? ☐ YES ☐ NO
   If yes, explain: _____

9. Does the adolescent have any wounds or injuries that heal slowly or have other complications? ☐ YES ☐ NO
   If yes, explain: _____

10. Has the adolescent had any joint replacements? ☐ YES ☐ NO Has the adolescent had any artificial limbs or lens implants? ☐ YES ☐ NO

11. Has the adolescent ever fainted or been knocked unconscious? ☐ YES ☐ NO
If yes, explain: _____

12. Is the adolescent on any special diet at this time? ☐ YES ☐ NO
If yes, explain: _____

13. Has the adolescent had x-ray treatment (besides for fractures and routine chest x-rays)? ☐ YES ☐ NO
If yes, explain: _____

14. Does the adolescent have any disease, condition or problem that you think the doctor or dentist should know about? ☐ YES ☐ NO
If yes, explain: _____

15. Is the adolescent pregnant? ☐ YES ☐ NO ☐ N/A

16. Has the adolescent had any trouble associated with dental treatment? ☐ YES ☐ NO
If yes, explain: _____

17. Is the adolescent current on immunizations? ☐ YES ☐ NO

18. Is there any suspicion that the adolescent is using drugs or alcohol? ☐ YES ☐ NO

Parent/legal guardian signature: _____ Date: _____

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Photo

Aalhakoffichi` will provide

Name: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Tattoos: _____ Hair Length: _____ Scars: _____

Remarks/details: _____

I, _____ being the parent/legal guardian of _____ hereby give Aalhakoffichi' staff authorization/responsibility to initiate proceedings for detention orders, missing persons reports, runaway juvenile reports and/or any documents/procedures needed in the event my adolescent leaves Aalhakoffichi' or the public school he is attending or any Aalhakoffichi' activities or school activities without expressed permission from Aalhakoffichi' staff. The permission is given so that my adolescent may be located and returned to a safe environment as soon as possible.

_____ _____

Signature of parent or legal guardian Date Signature of witness Date

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## AUTHORIZATION FOR TREATMENT AND DISCLOSURE OF CLINICAL INFORMATION

I am legally responsible for _____ and hereby give consent for any medical, dental, counseling, substance abuse screening and drug/alcohol treatment that become necessary while the adolescent resides at Aalhakoffichi'. I also approve such inoculations and treatments in the field of preventive medicine as may be deemed necessary by medical personnel.

I further understand that I will be notified by ATLC when emergency situations arise in any medical, dental, counseling, substance abuse screening and drug/alcohol treatment situations involving my adolescent while at ATLC.

I authorize this release knowing and understanding the records may contain information relating to a reportable communicable disease, which is confidential according to applicable law.

I further consent for the disclosure and exchange of pertinent information essential for medical treatment, drug/alcohol treatment and substance abuse screening or counseling services. This information may be exchanged between the _____ (name of medical provider) and the Aalhakoffichi` beginning _____ and ending _____.

Consent is given for a drug screening to be done upon acceptance of application.

_____ _____
Signature of parent/legal guardian Address

_____ _____
Relationship City State ZIP

_____ _____
Date Phone number

State of _____

County of: _____

Signed before me on _____ 20___

By _____

Identification _____

My commission expires _____

_____
Notary Public

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**PLEASE PRINT** DATE OF EXAM: _____

## MEDICAL HISTORY

Date of last doctor visit: _____

Name of medical facility: _____

Allergies: ☐ Yes ☐ No If yes, specify: _____

Medical problems: ☐ Yes ☐ No If yes, specify: _____

Current medications: ☐ Yes ☐ No If yes, specify: _____

## PREPARTICIPATION PHYSICAL EVALUATION

Name: _____ Birth date: _____

Height: _____ Weight: _____ Body fat (optional): _____% Pulse: _____

BP: _____/_____ _____/_____ _____/_____
Initial BP Post exercise 5 min. post ex.

Vision: R 20/_____ L 20/_____ Corrected: ☐ Yes ☐ No Pupils: Equal _____ Unequal _____

| MEDICAL | NORMAL | ABNORMAL FINDINGS: |
|---|---|---|
| Appearance | | |
| Eyes/ears/throat | | |
| Lymph nodes | | |
| Heart | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitalia (male only) | | |
| Skin | | |

MUSCULOSKELETAL

| | | |
|---|---|---|
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot | | |

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

☐ Not cleared for: _____ Reason: _____

Recommendations:

Name and title of examiner (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of examiner: _____

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# RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby give my consent to _____
(Parent/legal guardian) (Doctor, hospital, clinic, agency or school)

its directors, designee or records department, to release information contained in _____
(Adolescent's name)

DOB: _____ SSN: _____ Record number: _____

records to the individual or organization listed below:

1. Name or title of person(s) or organization to whom disclosure is to be made:

   ATTN: Aalhakoffichi'
   111 Arrowhead Drive
   Pauls Valley, Oklahoma 73075

   Method(s) of Release:
   ☐ Verbal telephone ☐ Written
   ☐ Electronic mail ☐ Fax

2. Specific type of information to be disclosed:
   ☐ Medical ☐ Psychological ☐ Vocational
   ☐ Other: _____

3. The purpose and need for such disclosure:
   ☐ Establish eligibility for services ☐ Case staffing
   ☐ Determine need for and/or type of treatment ☐ Other: _____

4. The confidential information I authorize for release may include information about communicable or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

5. I understand this release may be revoked at any time and shall be valid no longer than is reasonably necessary to accomplish the purpose for which it is given.

6. This release expires upon the resident's exit from Aalhakoffichi', unless otherwise indicated.

_____ _____ _____
Parent/legal guardian signature Date Relationship

_____ _____ _____
Witnessed by Title Date

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# PRIVACY ACT UNDERSTANDING AND LEGAL SIGNATURE FORM

I have read the Privacy Act Notice (Public Law 93-579) and have been informed that my adolescent's records are located in the health and medical records system at:

The Chickasaw Nation Medical Center

I understand that the information given by me or collected is necessary for the Chickasaw Nation Medical Center to provide services for my adolescent's health and well-being. Furthermore, I have been informed that my adolescent's records or any portion of the records shall not be disclosed to another agency or person unless specified as routine use without my signed consent.

I give permission for Aalhakoffichi' staff to accompany my adolescent to the health facility and to be in the examination room during appointments (with the exception of mental health appointments).

_____
Adolescent name

_____ _____
Signature of parent/legal guardian, if listed above is a minor. Date

_____ _____
Signature of witness Date

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# CONSENT FOR URINE DRUG SCREEN

**Adolescent name:** _____ **SSN:** _____ **Date:** _____

**Aalhakoffichi` has a zero tolerance substance abuse policy.**

In keeping with this policy it may be necessary to do random drug testing as needed while my adolescent is on the Aalhakoffichi' campus. I understand that this screening will be a urine drug screening. My signature below indicates that I give my consent for my adolescent to receive urine drug screens at Aalhakoffichi'. I further understand that staff of the same gender may observe collection of urine. Results from these screenings will be confidential and known only to necessary staff and that I will receive results if requested.

This consent is in effect from _____ to _____.
Date Date

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of witness Date

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# EDUCATION INFORMATION

Previous school attended: _____

Address: _____

Date and grades completed: _____

Please provide most current copy of your report card.

Reason for leaving if applicable: _____

_____

Has your adolescent: (check appropriate boxes)

Been retained in same grade? ☐ Yes ☐ No

Been tested for special education, Attention Deficit Disorder and/or Learning Disabilities Disorder?
☐ Yes ☐ No Please explain:

_____

Received speech therapy? ☐ Yes ☐ No

Been in special education classes or have classroom modifications? ☐ Yes ☐ No

**Consent for Release of Education Records**

I authorize _____School District and all education departments thereof to release all portions of my adolescent's educational record, which may be confidential or otherwise, including special education records, to:

Aalhakoffichi' (A place for healing)
111 Arrowhead Drive
Pauls Valley, Oklahoma 73075
(405) 331-2300
Fax: (405) 331-2302

Adolescent name: _____ Birth date: _____

Signature of parent/legal guardian: _____ Date: _____

*Attention*: According to the Family Educational Rights and Privacy Act of 1974 (Public Law 93-380) the parents, legal guardians or 18-year-old students have the right to make a written request to view any records released.

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# AALHAKOFFICHI' ADOLESCENT TRANSITIONAL LIVING CENTER

I, _____, understand and give my permission for my adolescent, _____, to participate in the adolescent transitional living center (ATLC) activities. I further understand some of these activities will be outside ATLC property and will require transporting my adolescent to events or activities. I give my permission for the Aalhakoffichi' staff to accompany my adolescent to program activities and other events when necessary. I understand I will be informed when my adolescent will be going to any such event.

## WAIVER OF RESPONSIBILITY OF PERSONAL INJURY AND/OR LIABILITY

By the presence of this document, be it known that I/we, _____ and
Parent/legal guardian

_____, do hereby waive the right of holding responsible the Chickasaw Nation, any
Participant
division within the Chickasaw Nation or any person or individual connected with instruction and/or participation in Aalhakoffichi' events and activities. I/We understand and acknowledge that there are hazards or dangers associated with participating in this program, and I/we agree to participate with knowledge of said dangers and hazards. Injury occurring to my/our adolescent or me/us either by direct or indirect means will be my/our sole responsibility. No individual or entity, including but not limited to, the Chickasaw Nation and divisions within the Chickasaw Nation, the ATLC staff or other participants, will be held liable for any damages or injuries. I/We have both read this entire form and it has been explained to us fully. Therefore, without coercion or duress, I/we affix our signatures to this document with full understanding of the statements contained herein, and agree to be bound by such agreement from this moment on for the duration of my/our adolescent's participation with the Aalhakoffichi' Program.

| _____ | _____ | _____ |
|---|---|---|
| Name of participant (print) | Signature of participant | Date |

| _____ | _____ | _____ |
|---|---|---|
| Name of parent/legal guardian | Signature of parent/legal guardian | Date |

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# AALHAKOFFICHI' ADOLESCENT TRANSITIONAL LIVING CENTER HANDBOOK

The Aalhakoffichi' Handbook is presented to each adolescent and parent/guardian during orientation or when the resident is admitted to Aalhakoffichi'. The staff has read or explained Aalhakoffichi` expectations and rules to the residents and parents/guardians.

I, _____ (resident), have been provided with the Aalhakoffichi' Handbook and understand that I must follow the guidelines outlined in this handbook. Nothing contained in this application, Aalhakoffichi' Handbook or any other Aalhakoffichi' documents shall be construed to waive the sovereign rights of the Chickasaw Nation, its officers, employees or agents.

Signature: _____ Date: _____

I, _____, parent/legal guardian of _____, have been provided with the Aalhakoffichi' Handbook and understand and will help my adolescent abide by the rules outlined within this handbook.

Signature of parent/guardian: _____ Date: _____

Signature of program director: _____ Date: _____

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# ***Adolescent Intake Form***

## I. Demographics

Last name: _____ First: _____ M.I.: _____

Address: _____ City: _____ State: ____ ZIP: _____

Birthplace: _____ Birth date: _____ Age: _____ Gender: _____

Ethnicity: _____ Tribal affiliation: _____

Telephone (home): _____ (office): _____ (cell): _____

Name of person completing form: _____

Are you the parent of the adolescent? ☐ Yes ☐ No
If no, are you the legal guardian? ☐ Yes ☐ No

In case of an emergency, contact: Name: _____ Telephone: _____

Address: _____

## II. Present life situation

**List all household members**

| Name | Age | Relationship | History of drug or alcohol abuse? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you live in: ☐ house ☐ apartment ☐ duplex ☐ other: _____

Do you have: ☐ running water ☐ electricity ☐ gas ☐ propane ☐ other: _____

How are your basic needs met? (sources of income): _____

Are you involved in social activities? ☐ Yes ☐ No
If yes, describe:

Have there been any significant changes to these activities in the past six months? ☐ Yes ☐ No
If yes, describe:

Is the adolescent's parent/guardian and/or another adult committed to the adolescent, willing to participate in therapeutic services? ☐ Yes ☐ No
If yes, describe:

***Parents' information:***

**Father's name**: _____ Occupation: _____

Address: _____

Education level: _____ Birth date: _____

**Mother's name**: _____ Occupation: _____

Address: _____

Education level: _____ Birth date: _____

***Stepparents' information*** *(if applicable)*:

**Name**: _____ Birth date: _____

Occupation: _____ Education level: _____

Describe the relationship with adolescent: _____

Schedule of visitation with non-custodial parent: _____

What was the age of the adolescent when stepparent entered the family? _____

## III. Medical/emotional history

Please list all inpatient and outpatient treatment for major medical/mental health issues.

| Reason | Where | When | How long? | Doctor/counselor |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Please list adolescent's primary care physician: _____

Is your adolescent on any medications? ☐ Yes ☐ No

If yes, please list (include over the counter medication):

Are there any significant allergies (including medication)? ☐ Yes ☐ No

If yes, please list:

Has there been any testing for possible special education and/or school placement? ☐ Yes ☐ No

If so, please list:

## IV. Development

***Pregnancy and labor***

Was there any complication related to the pregnancy of this adolescent? ☐ Yes ☐ No

If yes, please list:

Please list all medications taken during pregnancy:

During the pregnancy:

How many cigarettes were smoked a day? _____

How often was alcohol used? _____ Quantity: _____

How often were street drugs used? _____ Quantity: _____

Did the adolescent require oxygen at birth? _____

Was the adolescent cuddly as a baby? _____

Was the adolescent irritable as a baby? _____

***Developmental Milestones***

At what age did the adolescent:

Sit independently: Crawl: Walk independently:

Does the adolescent have difficulty with age appropriate activities? (e.g., riding a bike, catching a ball, dressing, etc.)

Does/did the adolescent coo, babble and generally respond to attempted communication?

## V. Education

What is the adolescent's current grade level? _____

Please list any problems the adolescent has experienced at school:

What adjustments have been made to address these problems?

Please indicate if the adolescent has a problem with:

…. alertness to the world around him/her? _____

…. attention span? _____

…. ability to problem solve? _____

…. ability to do math in his/her head? _____

…. appears to be on grade level with other adolescents his/her age? _____

Are there any speech, language, hearing, visual or other learning disabilities? If so, please describe:

Does the adolescent have an immunization record that has been verified by school? _____

## VI. Family history/relations

Please list if the biological parents' families:

…. had a history of depression or anxiety? _____

…. had a history of emotional abuse? _____

…. attempted or committed suicide? _____

…. used street drugs? _____

…. had a history of heavy drinking? _____

…. had problems with the law? _____

…. had other serious problems? _____

Describe the adolescent's parents' relationship to each other?

Describe the adolescent's relationship with his/her brothers/sisters:

- ☐ Good
- ☐ Fair
- ☐ Loving and affectionate
- ☐ Hits or aggravates
- ☐ Will not relate to them
- ☐ Poor
- ☐ Will not share
- ☐ Other: _____

Describe the adolescent's relationship with his/her peers:

- ☐ Good
- ☐ Fair
- ☐ Loving and affectionate
- ☐ Hits or aggravates
- ☐ Will not relate to them
- ☐ Poor
- ☐ Will not share
- ☐ Other: _____

Does the adolescent have a history of violent behaviors? ☐ Yes ☐ No If yes, please describe and include dates:

What responsibilities does the adolescent have at home?

What kinds of discipline are used in the adolescent's family? (Please check all that apply)

- ☐ Try to talk or reason with the adolescent
- ☐ Firm language
- ☐ Stand in corner
- ☐ Other: _____
- ☐ Spank
- ☐ Deny privileges
- ☐ Nothing works

Which of the above discipline methods seem to work the best?

Have there been any family disruptions, (e.g. death of family member, friend or pet, divorce, violence in the home, alcohol/drug use in the home, birth of sibling, remarriage, etc.) which might have affected the adolescent?

## VII. Abuse and trauma history

Has your adolescent ever been a victim of abuse or neglect? ☐ Yes ☐ No
If yes, please describe:

How has this affected your adolescent? _____

Has your adolescent ever been sexually molested? ☐ Yes ☐ No
If yes, when? _____

How has this affected your adolescent? _____

Has the adolescent ever been convicted of a crime? ☐ Yes ☐ No
If yes, please describe:

Has the adolescent ever purposely harmed himself/herself? ☐ Yes ☐ No If yes, describe what was occurring at the time, including when it took place:

Has the adolescent ever attempted suicide? ☐ Yes ☐ No
If yes, please provide date(s)? _____

Is your adolescent sexually active? ☐ Yes ☐ No

**Has your adolescent had struggles with:**
☐ Sexual identity ☐ Sexual conflict/guilt ☐ Sexual performance

## VIII. Addiction history

Has your adolescent been involved in risk taking behaviors (e.g. gangs, stealing, risky driving, DUI/DWI, etc.)?
☐ Yes ☐ No If yes, please describe:

How have these behaviors affected his/her personal life (e.g. home, school, work):

Has the adolescent been exposed to addictive behaviors (e.g. tobacco, alcohol, drugs, porn)? ☐ Yes ☐ No

If yes, please describe: _____

**Has the adolescent ever used drugs/alcohol? If yes, please answer the following:**

| | Daily | 2-3 x week | Once week | 2-3 x month | Once a month | 4-6 x year | Once a year | Age at 1st use | Date of last use |
|---|---|---|---|---|---|---|---|---|---|
| **Alcohol** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Marijuana** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Cocaine** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Heroin** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Methamphetamine** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Prescription drugs** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Other (name):** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Other (name):** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Smokeless tobacco:** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| **Smoking tobacco:** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |

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## Presenting problem

| Behavior problems | Age | Mild | Moderate | Severe |
|---|---|---|---|---|
| 1. Excessive crying | _____ | ☐ | ☐ | ☐ |
| 2. Excessive nail biting | _____ | ☐ | ☐ | ☐ |
| 3. Excessive vomiting | _____ | ☐ | ☐ | ☐ |
| 4. Thumb sucking | _____ | ☐ | ☐ | ☐ |
| 5. Frequent chewing on substances | _____ | ☐ | ☐ | ☐ |
| 6. Stuttering | _____ | ☐ | ☐ | ☐ |
| 7. Bed wetting after age 3 | _____ | ☐ | ☐ | ☐ |
| 8. Soiling after age 3 | _____ | ☐ | ☐ | ☐ |
| 9. Chronic constipation | _____ | ☐ | ☐ | ☐ |
| 10. Chronic diarrhea | _____ | ☐ | ☐ | ☐ |
| 11. Temper tantrums | _____ | ☐ | ☐ | ☐ |
| 12. Masturbation | _____ | ☐ | ☐ | ☐ |
| 13. Extreme shyness | _____ | ☐ | ☐ | ☐ |
| 14. Extreme goodness | _____ | ☐ | ☐ | ☐ |
| 15. Fighting and quarrelling | _____ | ☐ | ☐ | ☐ |
| 16. Lying | _____ | ☐ | ☐ | ☐ |
| 17. Stealing | _____ | ☐ | ☐ | ☐ |
| 18. Frequent nightmares | _____ | ☐ | ☐ | ☐ |
| 19. Sleep walking | _____ | ☐ | ☐ | ☐ |
| 20. Tics (muscle spasms or jerks) | _____ | ☐ | ☐ | ☐ |
| 21. Fears | _____ | ☐ | ☐ | ☐ |
| 22. Fire setting | _____ | ☐ | ☐ | ☐ |
| 23. Anxious states | _____ | ☐ | ☐ | ☐ |
| 24. Sexual problems | _____ | ☐ | ☐ | ☐ |
| 25. Problems with authorities | _____ | ☐ | ☐ | ☐ |
| 26. Withdrawal from friends | _____ | ☐ | ☐ | ☐ |
| 27. Running away | _____ | ☐ | ☐ | ☐ |
| 28. Eating disorder | _____ | ☐ | ☐ | ☐ |

Does the adolescent have any other specific fears, emotional reactions, behavioral problems, etc., that are a concern?

Please list any other specific question or concerns you would like the evaluation to address.

Is there any additional information that may be helpful to the evaluation of the adolescent?

Would you like information on advance directives? ☐ Yes ☐ No

_____ Date: _____