VOLUNTEERS OF AMERICA ALASKA
FAMILY/GUARDIAN QUESTIONNAIRE

The information obtained from this questionnaire is an important part of planning an effective treatment program. While you may not be able to answer all questions, be as thorough as possible. Your cooperation is appreciated. PLEASE PRINT.

Your Name_____ Child's Name _____

Your Relationship to the child: _____ How long have you known the child: _____

Please answer the following **prenatal/birth questions** as you are able:
Were there any complications during pregnancy with this child? If so, what type of issues?

Was there any drug or alcohol consumption during pregnancy with this child? If so, what types of drugs?

Were there any complications at this child's birth? If so, what type of issues?

Developmental History of Child:

Any delays in language development? ☐YES ☐NO

Any delays in reading or writing? ☐YES ☐NO

Any delays in motor development or functioning? ☐YES ☐NO

Any hearing, speech, or vision impairments? ☐YES ☐NO
(i.e. stuttering or other speech impediment, hearing deficit, eyeglasses or contacts.):

Describe any assistive technology needed for the child:_____

Head injuries/trauma: ☐YES ☐NO

Is the child allergic to any foods or medications or adverse reactions to anesthetics/antibiotics/medications? ☐YES ☐NO
If yes, to what? :

What special dietary needs that the child has? : ☐YES ☐NO

To the best of your knowledge, does this child have a history of:
Seizures: ☐YES ☐NO
Medical Complications (e.g., diabetes, asthma): ☐YES ☐NO
If yes, please describe any significant medical:_____
_____
_____

Where is the child currently living and with whom is the child living with (home with family, foster care, relative placement, treatment, MYC or other detention, homeless, etc.)?
_____

For Parents:
Number of children living in your household: _____

Number of people living in your household? _____

What is your total household income? _____

Are you currently living with the youth? _____

Is there any OCS involvement for this child? ☐YES ☐NO
If so, please provide OCS Case Worker's Name and Contact Info:_____

History of out of home placements for this child (e.g., shelter, foster care)? ☐YES ☐NO

If yes, has child had multiple out of home placements? ☐YES ☐NO
If yes, how many placements? _____

History of moves (including purpose for the move)
_____

How is the child presenting in the home? What is your overall impression of child's problem?
_____

_____

_____

Briefly describe the situation that brought the child for an assessment at this time:
_____

_____

_____

How long and/or how frequently has the problem been occurring?

_____

_____

What strengths does the child possess?

_____

_____

What are the child's weaknesses?

_____

_____

Has child has received previous treatment for chemical dependency and/or mental health problems? ☐YES ☐NO If, yes please answer the following:

a) Reason for treatment: _____

b) By what agency:_____

c) When/how long received services: _____

d) Results (helped, didn't help):_____

Does the child have a history of mental health diagnoses? If so, which diagnoses?

_____

_____

Please list all prescription medications child has taken or is taking:

_____

_____

Has the child ever threatened to commit suicide or attempted suicide? ☐YES ☐NO

If yes, please explain the circumstances, means, and whether or not child has received help for this: _____

_____

_____

_____

_____

Has the child ever been physically assaultive toward another person? ☐YES ☐NO
If yes, please describe circumstances and if drugs/alcohol were involved.

_____

_____

For each of these items listed below, please indicate if your child engages in any of these behaviors. (Check "yes" or "no")

a) Lying or blaming other for his/her problems ☐YES ☐NO
b) Social isolation ☐YES ☐NO
c) Theft of money or valuables ☐YES ☐NO
d) Lack of participation/interest in family activities ☐YES ☐NO
e) Increase in verbal or, physical abuse ☐YES ☐NO
f) Difficulty communicating ideas ☐YES ☐NO
g) Changes in eating habits ☐YES ☐NO
h) Changes in sleeping patterns ☐YES ☐NO
i) Changes in friends ☐YES ☐NO
j) Decrease in work and/or school performance ☐YES ☐NO
k) Decrease in participation in recreational/leisure time activities previously enjoyed. ☐YES ☐NO
l) Decrease in willingness to engage family members for support or in problem solving ☐YES ☐NO
m) Arrests for DWI/Minor Consuming Citations ☐YES ☐NO
n) Legal problems ☐YES ☐NO
o) Increase in accidents while under the influence of chemicals. ☐YES ☐NO
p) Health/medical problems. ☐YES ☐NO
q) Participation in high risk behaviors (e.g., multiple sexual partners, stealing, spending sprees) ☐YES ☐NO

If yes, did these changes begin after child started using substances? ☐YES ☐NO

Would you and your family like to meet with the VOA family support coordinator to discuss ways to improve family communications and to support the child while in treatment?
☐YES ☐NO ☐Not Sure

May we share this information with the child? Yes_____ No_____

_____ _____
Parent/Legal Guardian signature Date

Child Substance Use History

*****If not applicable, skip this questionnaire*****

To the best of your knowledge, does the child have any family history of addiction and/or mental health issues? If so, what (e.g., alcoholism, drug addiction, bipolar, depression)?

_____

_____

_____

Prior to problems with alcohol/drugs, briefly describe the child's personality, including how he/she got along with friends and acquaintances.

_____

_____

What type(s) of alcohol or other drugs does or has this child used?

_____

_____

How **often** does the child drink or use drugs? (i.e.; daily, weekly, monthly)

_____

_____

How **much** does the child typically drink/use each time (i.e.; number of drinks, joints, pills)?

_____

_____

Where does the child typically use?

_____

_____

With whom does the child typically drink or use drugs?

_____

Have you noticed an increase in the child's use of alcohol or other drugs? If yes, describe the child's initial use and what it has been like recently.

_____

_____

Have there been problems resulting from the child's drinking or drug use?

If yes, describe them:

Legal_____

Family_____

Personal_____

Has the child ever attempted to stop or limit his/her using? _____

What did child do to try to stop or limit using (i.e.; stopped on own; went to self-help group; 12-step program; or religious group meetings; contracted with friend or legal officer; etc.)?

_____

_____

What is the longest period of time the child has gone without using alcohol/drugs in the past two years?_____ When did this occur?_____

Has the child ever attended any self-help groups such as Alcoholics Anonymous (AA), Al-Anon, Alateen, Marijuana Anonymous (MA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), Nicotine Anonymous? ☐YES ☐NO

Were these meetings helpful for the child? ☐YES ☐NO

Signature_____ Date_____

Revised
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