005 PATIENT HEALTH PROFILE

St. Vincent Health

# YOUTH SERVICES QUESTIONNAIRE
## Youth Biopsychosocial Form

*Patient ID*

The following pages may be completed by the parent, the caregiver, and / or the therapist.

**DATE:** ____/____/____

**PATIENT NAME:** ______________________________ **BIRTH DATE:** ____/____/____ **AGE:**_____

**NICKNAME(S):** usually used______________________________ **SEX:** Male ☐ Female ☐

**LEGAL GUARDIAN(S):**______________________________

**NAME OF PERSON(S) COMPLETING THE FORM:** ______________________________

**RELATIONSHIP TO YOUTH:** ______________________________

**YOUTH SYMPTOM CHECKLIST INSTRUCTIONS:** Please read each item carefully. If an item applies to the youth now or in the past, please check the item.

| | | | |
|---|---|---|---|
| **BEHAVIOR** | | | Trouble concentrating |
| | Does things without thinking | | Feels sad often / cries easily |
| | Refuses "no" for answer | | Does not seem to feel guilt |
| | Destroys property or belongings | | Is extremely critical |
| | Steals | | Seems afraid to make mistakes / easily embarrassed |
| | Lies often | | Does not like to be touched |
| | Has been in trouble with police or probation | | Resents even gentle criticism |
| | Sexual problems | | Has an "I don't care" attitude |
| | Has run away from home | | Has a "you cannot make me" attitude |
| | Has attempted or talked about suicide | | Feels angry often |
| | Argues when told to do something | | Feels bored often |
| | Delays doing as asked | | Is afraid of "rough" play |
| | Cruel to animals | | Has frequent nightmares |
| | Wants everything his/her own way | | Other: |
| | Often tries to be the center of attention | **FAMILY** | |
| | Has temper tantrums or violent behavior | | Sleeps in bed with parents |
| | Acts like a younger child | | Avoids contact with family members |
| | Curses | | Parents get along poorly with each other |
| | Sets fires | | Clings to parents |
| | Nervous habits / anxiety / panic attacks | | Other: |
| | Often pouts and sulks | **SOCIAL** | |
| | Prefers to be alone / avoids activities | | Hangs around with a bad crowd |
| | Other: | | Is too easily led by others |
| **ACADEMIC** | | | Chooses younger friends ___ older friends___ |
| | Is truant from school | | Is often teased by others |
| | Does not complete assignments in classroom | | Does not like being alone |
| | Does not do homework | | Has few friends |
| | Feels unfairly treated by teachers or authorities | | Tattles on other children |
| | Short attention span | | Teases other children |
| | Often clowns around in class | | Seems shy |
| | Refuses to go to school | | Often boasts |
| | Is poorly organized in seat work | | Often interrupts others |
| | Poor handwriting / sloppy work | | Will not argue or fight back when most would |
| | Cannot sit still | | Fights |
| | Makes grades below ability | | Has EVER been sexually molested |
| | Has difficulty working in groups | | Uses alcohol |
| | Rarely speaks up in the class | | Uses drugs |
| | Rarely works without individual attention | | Sells drugs |
| | Test anxiety | | Smokes cigarettes |
| | Fears teacher(s) | | Other: |
| | Trouble on the bus | **PHYSICAL** | |
| | Other: | | Frequent physical complaints |
| **THINKING / ATTITUDE** | | | Trouble falling asleep___ Sleeps too much___ |
| | Seems preoccupied with certain thoughts | | Is tired much of the time |
| | Daydreams more than most | | Is seriously overweight___ Underweight___ |
| | Says or does things over and over | | Lost weight ___ Gained weight ___ |
| | Hears or sees things that are not there | | Hearing problems___ Speech problems___ |
| | Seems unaware of what is happening | | Vision problems |
| | Lacks self-confidence | | Poor bladder control days___ nights___ wets bed___ |

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### 1. DESCRIPTIONS OF GOALS:
What behaviors and talk will you see and hear after things are better? Include what will be different for child and family. (For example: "We will be talking through problems without yelling at each other.")

A. ____________________

B. ____________________

C. ____________________

### 2. WHO LIVES IN THE CHILD'S HOME?

| FAMILY MEMBER / SIGNIFICANT OTHER / OTHER | AGE | RELATIONSHIP TO PATIENT | AVERAGE HOURS WORKED PER WEEK | OCCUPATION |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### 3. CARETAKERS / OTHER IMPORTANT PERSONS:
List parents, siblings (biological, step, or adoptive), and other important persons who are not currently in the home:

| NAME | AGE | CITY | RELATIONSHIP | FREQUENCY SEEN |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Describe how the child gets along with the above persons:

IF the above list includes a parent, list address, home, work, and cell phone numbers:

Name: ____________________

Address: ____________________

Home Phone: ____________ Work Phone: ____________ Cell: ____________

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4. **SOCIAL AGENCIES:** Please list any welfare, children's services connections, or social agencies involved with your family: None ☐

5. Is the child **ADOPTED?** No ☐ Yes ☐ If yes, age of child when adopted: ________

   Is the child a **FOSTER CHILD?** No ☐ Yes ☐ If yes, list caseworker's information:

   Caseworker's Name: ______________________ Phone: ______________ County: ______

6. **CHILD'S BIOLOGICAL PARENTS ARE NOW:**

   ☐ **Never Married** ☐ and together ☐ and separated, list date separated: __________

   ☐ **Married** How many years? _________

   ☐ **Separated** Date separated: _________

   ☐ **Divorced** Date divorced: _________

   Has either parent remarried? No ☐ Yes ☐ If yes, when: __________

   ☐ **Deceased** List relationship and date deceased: ______________________

7. **CUSTODY AND VISITATION:**
   If divorced or separated, what is the custody arrangement and what is the visitation arrangement? How well do these arrangements work?
   ☐ Not applicable

8. **PATIENT HEALTH INFORMATION:**

   A. **BIRTH WEIGHT:** _______
   Any problems with the pregnancy or delivery? No ☐ Yes ☐ If yes, please describe:

   B. **DEVELOPMENTAL MILESTONES:** (List any problems below)
   Infancy: Birth to two years. List any significant delays / problems such as feeding problems or slow to walk or talk: None ☐

   Toddler / preschool: 2-5 years. List any developmental delays or difficulties such as trouble with toilet training, speech, or self care: None ☐

   School age: 8-12 years. Describe any delays or problems such as attention problems, refusal to attend school, or issues with puberty: Not applicable ☐ None ☐

   Middle / High School: 13-18 years. Describe any delays / problems: Not applicable ☐ None ☐

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**C. VISION:** Glasses / contacts? No ☐ Yes ☐ (describe) ______

**D. PHYSICAL HANDICAPS or PHYSICAL CHALLENGES:** None ☐ Yes ☐ If yes, please describe:

**E. NUTRITION:** Appetite is usually: Good ☐ Excessive ☐ Poor ☐ Variable ☐
Dental braces/appliances: None ☐ Yes ☐ (describe) ______
Do you have any concerns about the child's eating patterns or nutrition? No ☐ Yes ☐
If yes, please describe:

Is there a history of vomiting, bingeing, or excessive preoccupation with food? No ☐ Yes ☐
If yes, please describe:

Does the child have any difficulty with eating or swallowing? No ☐ Yes ☐ If yes, please describe:

**F. MENSTRUATION:** Not applicable ☐ Has menstruation begun? No ☐ Yes ☐
If yes, at what age did menstruation begin? ______
Has menstruation been: Regular ☐ Painful ☐
Do you think there are excessive signs of "PMS": (premenstrual syndrome)? No ☐ Yes ☐
If yes, please describe:

**9. SCHOOL INFORMATION:** ***(If in Day Care or Pre-school, please fill out as applicable)***

Name of School: ______ School Phone: ______

School Address: ______

Present Grade Level: ______ Special placement or classes? ______

Current Teacher: ______ Current Counselor: ______

Began school at what age? ______ Adjusted to school: Easily ☐ With Difficulty ☐

Repeated a grade? No ☐ Yes ☐ If yes, list grade(s) repeated: ______

Best subjects: ______

Hardest subjects: ______

Most grades have been: A B C D F When, if ever, did work begin declining? ______

How does your child best learn? Reading ☐ Hearing ☐ Watching ☐ Hands-on ☐

Expulsions / Detentions / Suspensions? None ☐ Yes ☐ If yes, please describe:

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Describe relationships with other students and teachers:

Additional comments about recent school behaviors?

**10. SPIRITUAL BACKGROUND:** Past and present religious affiliation, involvement in church, guiding spiritual principles:

What particular spiritual/religious issues would you like help addressing with your child? None ☐
Prayer ☐ Faith community ☐ Spiritual friend ☐ Spiritual reading ☐ Church attendance ☐
Other: ____________________

Would you like to discuss any of these spiritual issues with someone? No ☐ Yes ☐

**11. FAMILY INFORMATION:**

**A. RESIDENCES:** Number of times the family has moved since the child was born: __________
Date of most recent move: __________

**B. DISCIPLINE:** What forms of discipline do you use when correcting your child? Indicate the form(s) that you think work best for your child and family:
Time outs ☐ Grounding ☐ Loss of toy / privilege ☐ Spanking ☐ Praise ☐
Contracts ☐ Rewards ☐ Other (describe):

Who is the main disciplinarian in your home?____________________

Is there anything you want to write about the rules in your child's home(s) and how discipline occurs? No ☐ Yes ☐ If yes, please describe:

**C. LEISURE / HOBBIES / PLAY:** What does your child enjoy doing in his / her free time? In what social activities, extracurricular activities, lessons or sports is he / she involved?

What kinds of activities does your **FAMILY** enjoy together?

**D. FINANCIAL:** How would you describe your current financial status? (Describe any financial concerns you have currently):

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E. **CHANGES:** Any other changes such as friends moving, changes in custody, parents' work hours, parents' health, etc.? None ☐ Yes ☐ If yes, please describe:

G. **MILITARY SERVICE:**
Is anyone in the immediate family currently serving in the Armed Forces? No ☐ Yes ☐

Has past service in the Armed Forces affected this family's history and relationships?
No ☐ Yes ☐ If yes, please describe:

12. **FRIENDS / SOCIAL:** Do you have any concerns about your child's ability to choose and maintain friendships? No ☐ Yes ☐ Comments or concerns about your child's friendships:

13. **CULTURAL: Ethnicity / race:** ____________________
Are there any family cultural values or traditions we need to know about? (Foods, family organization, customs, etc.): No ☐ Yes ☐ If yes, please describe:

14. **STRENGTHS AND DIFFICULTIES:**
What strengths or talents does your child have?

What difficulties or limitations does your child have?

15. **PAST COUNSELING EXPERIENCES:** Please list names and dates of psychiatrists, counselors, psychiatric clinics or hospitals consulted for your child:
None ☐

**TESTING:** If psychological or educational testing has been done, summarize findings: None ☐

16. **OTHER INFORMATION:** Is there any other information about your child or family which you think would be helpful for us to know? None ☐

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**STAFF SECTION:** ☐ Reviewed

**CONCLUSIONS AND RECOMMENDATIONS:**
- High risk patient and / or family psychosocial issues requiring early treatment planning and immediate intervention
- Specific community resources / support systems
- Anticipated discharge plans

☐ See initial assessment

Signature: ______________________ Date: __________ Time: __________