

## YOUTH/FAMILY ASSESSMENT QUESTIONNAIRE

*Please complete entire form in order to assist us in identifying services available to your family.*

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_  
First                      Middle                      Last

Person completing form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Child's Primary address**

Address: \_\_\_\_\_  
Street                      Apt. No.                      City                      State                      Zip

Home Phone ( \_\_\_\_ ) \_\_\_\_\_ Cell phone ( \_\_\_\_ ) \_\_\_\_\_

Child resides with:    Both Parents    Mother    Father    Other: \_\_\_\_\_

Child's Race/Ethnicity \_\_\_\_\_ Child's Primary Language \_\_\_\_\_

Child's Sex    Male    Female    Child's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is your child a U.S. Citizen?    YES    NO    If no, nation of origin \_\_\_\_\_

*Please provide a copy of your child's birth certificate and Social Security card*

Is your child Native American    YES    NO    If yes, Tribal Affiliation \_\_\_\_\_

Is your child Adopted:    YES    NO    If yes, age adopted: \_\_\_\_\_

**Child's Physical Features**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_

Skin Complexion:    Dark    Medium    Light

Body Build:    Average    Stocky    Slender    Overweight

Distinguishing Marks (Tattoos or scars)    YES    NO    Describe: \_\_\_\_\_

**Child's Family**

Mother or Female Guardian:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
First                      Middle                      Last

Race/Ethnicity: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary language (if not English): \_\_\_\_\_

Marital Status:    Married    Separated    Divorced    Cohabiting    In a relationship    Never married

Address: \_\_\_\_\_  
Street Apt. No. City State Zip

Home Phone ( \_\_\_\_ ) \_\_\_\_\_ Cell phone ( \_\_\_\_ ) \_\_\_\_\_

Highest educational level obtained: \_\_\_\_\_

General health: Good Fair Poor

If poor health, please explain: \_\_\_\_\_

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_ Work Phone ( \_\_\_\_ ) \_\_\_\_\_

Employment: Full time Part time Temp Laid off Unemployed Disabled Retired

Individuals living in Mother/Female Guardian's Household:

Name	Date of Birth	Relationship to Youth

Describe mothers/female guardian's relationship with child: \_\_\_\_\_  
\_\_\_\_\_

Has the mother/female guardian had any serious problems with any of the following?

- Substance Abuse      Alcoholism      Legal Problems      Physical Abuse
- Verbal Abuse          Sexual Abuse          Emotional Problems

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Mother's or female guardian's spouse or significant other (if any) Name: \_\_\_\_\_

DOB : \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. No. City State Zip

Years/months together: \_\_\_\_\_ Relationship with child: Good Fair Poor

Employer of Spouse or Significant other \_\_\_\_\_ Work Phone ( \_\_\_\_ ) \_\_\_\_\_





Has either parent been investigated by Child Protective Services?    YES    NO

If yes; who, reason, and number of times: \_\_\_\_\_

\_\_\_\_\_

Were charges substantiated?    YES    NO

Is there a Court Order for Neglect or abuse?    YES    NO

If yes, please explain the reason why: \_\_\_\_\_

\_\_\_\_\_

If yes, who is your child currently placed with? \_\_\_\_\_

Has your child ever been in Foster Care?    YES    NO

If yes, with whom was your child placed and when? \_\_\_\_\_

Reason: \_\_\_\_\_

**Child's Educational History**

Current School Status:    Attending    Dropped Out    Expelled    Currently Suspended

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Grade Average: \_\_\_\_\_

Approximately how many days has your child been absent from school this school year? \_\_\_\_\_

Please list common reasons for school absences: \_\_\_\_\_

Child's literacy:    Able to read    Unable to read  
                           Able to write    Unable to write

Does your child have problems with any of the following at school?

- Skipping
- Tardiness
- Not doing schoolwork
- Not turning in schoolwork
- Misbehavior
  
- Defiance
- Authority Problems
- Teasing/Bullying
- Fighting

Explain: \_\_\_\_\_

\_\_\_\_\_

Has your child been suspended from school?    YES    NO

If yes, approximately how many times and when? \_\_\_\_\_

Please list common reasons why your child is suspended: \_\_\_\_\_

Has your child ever been expelled from school?      YES      NO

If yes, when and why? \_\_\_\_\_

Has your child been tested for special education services?      YES      NO

Is your child enrolled in Special Education?      YES      NO

List the name(s) of the special education classes that your child is attending: \_\_\_\_\_

Does your child have any of the following impairments?      YES      NO

If yes, check all that apply:      Physical – Describe: \_\_\_\_\_  
Intellectual  
Emotional  
Developmental  
Learning  
Attention  
Hyperactivity/Impulsivity

Has your child seen a school social worker/school psychologist?      YES      NO

If yes, when and why? \_\_\_\_\_

Does your child participate in any school or after-school activities?      YES      NO

If yes, what are they? \_\_\_\_\_

**Child’s Social Relationships**

How many close friends does your child have?      Many      Few      None

Do you see your child’s friends as a positive or negative influence? \_\_\_\_\_

Does your child have a hard time making or keeping friends?      YES      NO

If yes, explain: \_\_\_\_\_

Is your child in a gang?      YES      NO      If yes, which one? \_\_\_\_\_

Does your child have a job?      YES      NO      If yes, where and for how long? \_\_\_\_\_

Does your child attend religious activities?      YES      NO      If yes, where? \_\_\_\_\_

How does your child spend his/her free-time? \_\_\_\_\_

\_\_\_\_\_

**Child’s Emotional/Psychological History**

Parental Observations

Has your child ever showed evidence of self-harm (scratching, cutting, burning, etc.)?      YES      NO

If yes, Explain \_\_\_\_\_

Has your child ever experienced any homicidal or suicidal thoughts?      YES      NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Stress and Losses

In the last few months have fears, worries, or sadness affected your child’s usual behavior?      YES      NO

Sleep      Nightmares      Stomach Aches      Energy      Concentration      Appetite

Has your child experienced any problems with any of the following:      YES      NO

Substance Abuse      Alcoholism      Fighting      Bullying      Physical Abuse

Verbal Abuse      Sexual Abuse      Emotional Problems      Other

If yes, please explain: \_\_\_\_\_

Has there been any alcohol or drug abuse in your child’s home?      YES      NO

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Has there been violence in your child’s home(s)?      YES      NO

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Has your child experienced any deaths, abandonments, rejections, or other losses? YES NO

Who: \_\_\_\_\_ When: \_\_\_\_\_

Who: \_\_\_\_\_ When: \_\_\_\_\_

Who: \_\_\_\_\_ When: \_\_\_\_\_

How many residential moves has your child experienced?

From \_\_\_\_\_ to \_\_\_\_\_ When: \_\_\_\_\_

Outpatient Treatment History

Has your child had any prior outpatient counseling? YES NO

Counselor: \_\_\_\_\_ Agency: \_\_\_\_\_

When: \_\_\_\_\_ Why: \_\_\_\_\_

What was his/her diagnosis? (if known) \_\_\_\_\_

Were prescription medications recommended? YES NO

Were the recommendations followed? YES NO

If followed were they beneficial? YES NO

Is your child currently taking any medications for a **psychological** condition? YES NO

If yes, please list them: \_\_\_\_\_

Inpatient Treatment History

Has your child been hospitalized for behavioral health treatment? YES NO

If yes, please check all that apply:

- Psychological problems
- Substance use disorder

If yes, on how many occasions? \_\_\_\_\_ Age(s) of child at the time: \_\_\_\_\_

Inpatient Facility Name(s) and City: \_\_\_\_\_

What was the diagnosis, if known? \_\_\_\_\_

Was continued counseling recommended?      YES      NO

Were prescription medications recommended?      YES      NO

Were the recommendations followed?      YES      NO

If followed, were they beneficial?      YES      NO

Comments: \_\_\_\_\_

**Child's Medical History**  
Developmental Information

Age of mother at time of birth: \_\_\_\_\_ Was there adequate prenatal care?      YES      NO

Were there any complications with child's birth?      YES      NO

If yes, explain: \_\_\_\_\_

Did the mother use any of the following during pregnancy?      YES      NO

Alcohol      Tobacco      Drugs (If drugs, which ones? \_\_\_\_\_ )

Has your child had developmental delays (sitting, walking, talking, intellectual disabilities, etc.)?      YES      NO

If so, please explain: \_\_\_\_\_

Medical Information

Child's Primary Care Physician or medical office: \_\_\_\_\_

Date of last doctor's visit: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Does your child have any **medical** conditions?      YES      NO      Describe: \_\_\_\_\_

Is your child taking any medications for a **medical/physical** condition?      YES      NO

If yes, list them and the condition(s) they treat: \_\_\_\_\_

Has your child been hospitalized for any medical condition(s):      YES      NO

If yes, when and for what condition(s): \_\_\_\_\_

Insurance Information:

Ins. Company Name \_\_\_\_\_

Medicaid ID# \_\_\_\_\_

Phone ( \_\_\_\_ ) \_\_\_\_ \_\_\_\_\_

Medicaid Caseworker \_\_\_\_\_

Policy No. \_\_\_\_\_

Contract No. \_\_\_\_\_

Group No. \_\_\_\_\_

*Please provide a copy of your child's insurance card*

**Additional Information**

Please provide any additional information you believe will be helpful for the court to know when assessing your child and family for needs, strengths, and available services:

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**I declare that the information in this questionnaire is true to the best of my information, knowledge, and belief.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date