rosecrance

ROSECRANCE GRIFFIN WILLIAMSON CAMPUS
Family / Guardian – Adolescent Assessment

If you have completed this form within the past 6 months, please only update any information that has changed. Please complete and give to the Access Counselor during your assessment.

Family Member / Parent / Guardian / Significant Other (Name/relationship): _____

Client Name:		Client DOB:	
Cell Phone:		Alternative Phone:	

Precipitating Events:

What brings you and the client to this appointment today?

To your knowledge, does your child use any drugs or alcohol? If so, what substance, and how often?

Were there any significant incidents that occurred in the client's early years such as divorce, death, abuse, etc.? If so, please describe:

How has your loved ones' behavioral health issues affected you and your family?

- ☐ Physical altercations
- ☐ Verbal altercations
- ☐ Social embarrassment
- ☐ Financial distress
- ☐ DCFS Involvement
- ☐ Community embarrassment
- ☐ Legal problems
- ☐ Excessive worry
- ☐ Breaking of house rules
- ☐ Stolen money / credit cards
- ☐ Broken promises
- ☐ Other:
- ☐ Employment problems
- ☐ Educational problems
- ☐ Insomnia
- ☐ Depression
- ☐ Lack of support

What are some consequences the client has suffered as a result of their drug and/or alcohol use, and/or mental health diagnoses:

- ☐ Loss of family support
- ☐ Educational Problems
- ☐ Suspension/Expulsion
- ☐ Loss of time from work
- ☐ Emotional problems
- ☐ Loss of friends
- ☐ Depression
- ☐ Personality changes
- ☐ Health Problems
- ☐ Financial problems
- ☐ Physical altercations
- ☐ Spiritual deterioration
- ☐ Legal problems (burglary, violence, DUI)_____
- ☐ Emotional/Physical/Sexual abuse:
- ☐ Other: _____

What are the client's strengths?

What are the client's areas requiring improvement?

Behavioral / Emotional
How does the client deal with problems?
Has the client shown signs of depression?
Has the client ever left home or school without permission?
Has the client ever had suicidal thoughts or a plan?
Has the client ever made a suicide attempt?
Has the client ever exhibited violent or aggressive behavior?
What has been helpful in managing these behaviors?

Friends / Leisure Time	
Have you met your child's friends? ☐ Yes ☐ No	Explain:
Do you approve of these friends? ☐ Yes ☐ No	Explain:
Any recent changes in the client's friends? ☐ Yes ☐ No	Explain:
Are you aware if any of the client's friends use drugs or alcohol? ☐ Yes ☐ No	Explain:
Do you approve of how the client spends their free time? ☐ Yes ☐ No	Explain:
Free time activities (both negative and positive), and any other concerns that you have about the client's social interactions:	

Legal:		
Has the client ever had any legal involvement, arrests, or periods of incarceration? If so, please complete details below:		
Date	**Offense**	**Current Status**
Is the client on parole or probation? ☐ Yes ☐ No	Reason:	
When was the 1st time arrested?	Reason:	

Treatment History:			
Has the client ever received treatment for behavioral health issues in the past? (Hospitalization, Intensive Outpatient, Individual Counseling, etc.) If so, please complete details below:			
Agency/Facility/Hospital/Counselor	**Dates**	**Reason**	**Outcome**

Family Behavioral Health History:
Are you aware of any of the client's biological relatives having behavioral health issues in the past or present? If so, please provide any details that you are comfortable sharing:

Medical Issues/Diagnoses:
Does the client have any **medical diagnoses**? If yes, please list:
Has the client had any recent **surgeries**? If so, when, and what was the procedure? What is the recommended follow up? What is the current treatment?
Does the client have **asthma**? (if so and the client is admitted, must have inhaler)
Does the client have any **heart conditions**? (Murmurs, surgeries, pacemaker, etc.)
Has the client been diagnosed with **diabetes**?
Has the client had any **broken bones** in the past 6 months? If so, what and when? What is the current treatment?
Does the client have any **food or drug allergies**? If so, please list:
Has the client ever had a **seizure**? If so, when? Was it related to drug use/withdrawal? What was the follow up to the seizure?

Is the client **prescribed any medications** currently? Please list below:

Medication Name	Dose	Frequency	Compliant?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

If the client is NOT taking any of their prescribed medications, please explain:

For Residential Admissions Only:	
Is the client welcome to return home after they complete treatment?	☐ Yes ☐ No
Is their return home contingent upon progress in treatment?	☐ Yes ☐ No
Is the home of the client supportive of recovery?	☐ Yes ☐ No
Do alternate living arrangements need to be explored?	☐ Yes ☐ No

Please use the space below to provide any additional details that you feel may be helpful for us to know:

Reviewed and appropriately integrated into treatment plan _____