Piedmont Psychiatric Clinic Child- Adolescent Data Base

Today's Date: ____________ Your Name: ____________________________ Age: _______ Birth date: _________________

Describe the Problem(s) as you see it: ____

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____

What do your parents think about it? ____

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____

Are things not as serious as or worse than everybody thinks? ____

Have you confided in anyone about what the problem is? Yes No Who? _________________________

Was it ok with you to come here today? Yes No

Have you been in counseling before? Yes No

Did it help? ____

Did you feel comfortable talking to a counselor? ____

Was there anything good or bad about counseling? ____

____

Did you take medications? Yes No Did they help? Yes No

Was there anything about the medicines you would like to share? Yes No

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____

Childs Questionnaire: Please read the questions listed below and circle True or False

#	Statement		
1.	I am not happy with the way I look	True	False
2.	I am angry a lot of the time	True	False
3.	I worry more than other people	True	False
4.	I think I am fat / need to loose weight	True	False
5.	I have trouble paying attention	True	False
6.	I have or I want to hurt myself	True	False
7.	I feel sad a lot / feel like crying	True	False
8.	People tease me / make fun of me	True	False
9.	I have secret(s)	True	False
10.	I have done something nobody knows about	True	False
11.	I think about death a lot	True	False
12.	I am / have been in trouble at school	True	False
13.	I do not sleep well / I have nightmares	True	False
14.	I act before I think	True	False
15.	I hear voices no one else hears	True	False
16.	I see things no one else sees	True	False
17.	I am worried about my family	True	False
18.	I do not think I am smart	True	False
19.	I don't have close friends	True	False
20.	I wish I were somebody else	True	False
21.	I do not feel like doing anything	True	False
22.	I am afraid	True	False
23.	I am not good at anything	True	False
24.	I do not have a happy family	True	False
25.	There is no one I can talk to about what really bothers me	True	False
26.	I can't do anything right	True	False
27.	Somebody broke my heart	True	False
28.	I have hurt other people or animals	True	False
29.	Sometimes, I wish I were dead	True	False
30.	No one cares whether I am around or not	True	False
31.	My father / mother/ parents is or are very strict	True	False
32.	I have regrets	True	False
33.	I do not like to be around other people	True	False
34.	People think I am weird / a freak	True	False

Do you have any questions or worries about your health? Yes No

What are your Concerns? ____

Substance Use: Do you use any of the following items listed below?

Drink Alcohol?	Yes	No	How Much? _________	How Often? _________
Smoke Cigaretts / Tobacco?	Yes	No	How Much? _________	How Often? _________
Illegal Drugs?	Yes	No	Please write the information below:	

NAME: ________________	LAST USED ________________	NAME: ________________	LAST USED ________________
NAME: ________________	LAST USED ________________	NAME: ________________	LAST USED ________________
NAME: ________________	LAST USED ________________	NAME: ________________	LAST USED ________________

Who lives in your house? Please indicate name, age, relationship to you. (I.e. full brother or sister, half brother or sister, step brother or sister, adopted brother or sister, step parent, grand parent, aunt, uncle, friend boyfriend, etc.)

Name	Age	Relationship to you	Do you get along with them?
______________	_____	______________	____________________________
______________	_____	______________	____________________________
______________	_____	______________	____________________________
______________	_____	______________	____________________________
______________	_____	______________	____________________________
______________	_____	______________	____________________________

Parents not living in the house with you:

Name	Age	Relationship to you	Do you get along with them?
______________	_____	______________	____________________________
______________	_____	______________	____________________________
______________	_____	______________	____________________________
______________	_____	______________	____________________________

What are things like at home? ____

____

____

Do you go on overnight visits? Example, with other parent (if parents are divorced), grand parents, other relatives, neighbors, etc.
____

What do you like about going there? ____

What do you dislike about going there? ____

What school do you go to? ______________________________ Grade: ___________________

How are your grades? (check appropriate box) Excellent Good Ok Bad

How do you like school? (check appropriate box) Love it It's ok I hate it

Do you have friends in school? (check appropriate box) Tons of them A few No

Are there things that bother you at school? ____

Who makes the rules at home? ____

What methods of punishment are used? ____

Do you have regular chores & responsibilities at home? Yes No

If yes, what are they? ____

Do you have a curfew? Yes No

Do you sleep over at friends? Yes No Do you have friends sleep over at your house? Yes No

Do you go to church? Often Now & Then Never What Church? ____________________

Do you belong to any youth groups? Yes No Which ones: __________________________________

Do you participate in activities outside of school? Yes No Which ones: ________________________________

What do you like about the way you look? ____

What are the things that you like about your life? ____

Has any body ever done things that made you feel uncomfortable? (check all boxes that apply)

Looking at you Yes No, Touching Yes No,
Saying Things Yes No Other Behavior Yes No

What changes would you like to see in your life? ____

Are there things you wrote here that you **do not** want us to discuss with your parents? Yes No

Is there anything else you think might be important for us so we can understand what is going on? Yes No

If yes, what is it? ____

____

Your Name: ______________________________________ Today's Date: ___________________________

The End