



Please list all allergies and medication side effects: \_\_\_\_\_

If you or anyone in your family has a history of thyroid disorder, if yes please explain: \_\_\_\_\_

History of head trauma: \_\_\_\_\_ Yes \_\_\_\_\_ No History of fractures: \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answered yes to any of these, please explain: \_\_\_\_\_

**SUBSTANCE USE AND ABUSE:**

Tobacco/Nicotine \_\_\_\_\_ Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_ Marijuana \_\_\_\_\_ Cocaine/Crack \_\_\_\_\_  
Spice \_\_\_\_\_ Heroin \_\_\_\_\_ Hallucinogens \_\_\_\_\_ Methamphetamines \_\_\_\_\_ Benzodiazepines \_\_\_\_\_  
Inhalants \_\_\_\_\_ Ecstasy \_\_\_\_\_ Other: \_\_\_\_\_

If yes to any of the above, please state time of use and amount used: \_\_\_\_\_

**BEHAVIORAL HEALTH INFORMATION:**

Please list current/previous behavioral health diagnosis: \_\_\_\_\_

Please list current/previous behavioral health treatment (Including chemical dependency treatment):

_____ Inpatient	Dates _____	Facility _____	Location _____
_____ Outpatient	Dates _____	Facility _____	Location _____
_____ Therapy	Dates _____	Facility _____	Location _____
_____ Psychiatrist	Dates _____	Facility _____	Location _____

Briefly describe your reason for consultation today: \_\_\_\_\_

How long has this been a problem for you? \_\_\_\_\_

Please list current symptoms: \_\_\_\_\_

Please provide additional information you feel is important: \_\_\_\_\_

[Type text]

## Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

Version [GVER]: GSS 3.0.1

Name: \_\_\_\_\_

Date: \_\_\_\_\_

First/Middle/Last

The following questions are about common psychological, behavioral and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.

	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
<p>After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.</p>					
<b>IDSscr</b>					
<u>When was the last time you had significant problems...</u>					
• with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?.....	4	3	2	1	0
• with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?.....	4	3	2	1	0
• feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?.....	4	3	2	1	0
• becoming very distressed and upset when something reminded you of the past?.....	4	3	2	1	0
• thinking about ending your life or committing suicide?.....	4	3	2	1	0
• seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?.....	4	3	2	1	0
<b>EDSscr</b>					
<u>When was the last time that you did the following things two or more times?</u>					
• Lied or conned to get things you wanted or to avoid having to do something?.....	4	3	2	1	0
• Had a hard time paying attention at school, work, or home?.....	4	3	2	1	0
• Had a hard time listening to instructions at school, work, or home?....	4	3	2	1	0
• Had a hard time waiting for your turn?.....	4	3	2	1	0
• Were a bully or threatened other people?.....	4	3	2	1	0
• Started physical fights with other people?.....	4	3	2	1	0
• Tried to win back your gambling losses by going back another day?....	4	3	2	1	0

<i>(Continued)</i>					
After each of the following questions, please tell us the last time you had this problem, if ever, by answering (circling) whether it was in the past month (4), 2-3 months ago (3), 4-12 months ago (2), 1 or more years ago (1), or never (0). Be sure to choose only one response.					
	Past Month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
<b>SDSscr</b>					
<u>When was the last time that...</u>					
• you used alcohol or other drugs weekly or more often?.....	4	3	2	1	0
• you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (feeling sick)?.....	4	3	2	1	0
• you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?.....	4	3	2	1	0
• your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?.....	4	3	2	1	0
• you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?.....	4	3	2	1	0
<b>CVSscr</b>					
<u>When was the last time that you...</u>					
• had a disagreement in which you pushed, grabbed, or shoved someone?.....	4	3	2	1	0
• took something from a store without paying for it?.....	4	3	2	1	0
• sold, distributed or helped to make illegal drugs?.....	4	3	2	1	0
• drove a vehicle while under the influence of alcohol or illegal drugs?..	4	3	2	1	0
• purposely damaged or destroyed property that did not belong to you?..	4	3	2	1	0

Do you have other significant psychological, behavioral or personal problems that you want treatment for or help with? If yes, please describe: \_\_\_\_\_ Yes \_\_\_\_\_ No

Client Signature _____	Date _____
<b>Staff Use Only</b>	
Number of 2's, 3's, and 4's: IDSscr: _____ EDSscr: _____ SDSscr: _____ CVSscr: _____ TDSscr: _____	
Referral: _____ MH _____ SA _____ ANG _____ Other: _____	

# Strengths and Difficulties Questionnaire

P or T <sup>11-17</sup>

*Parent to complete*

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name .....

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other youth, for example books, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Would rather be alone than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other youth or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often offers to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees work through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature .....

Date .....

Parent / Teacher / Other (Please specify):

**Thank you very much for your help**

## Strengths and Difficulties Questionnaire

S11-17

*Student to complete*

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your name.....

Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others, for example CD's, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather be alone than with people of my age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often offer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get along better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature .....

Today's Date .....

**Thank you very much for your help**