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HEALTH QUESTIONNAIRE
(Clients 18 years and younger)

Northland Counseling Center, Inc.
215 Southeast Second Ave., Grand Rapids, MN 55744
Phone: 218-326-1274

Please complete the information below on the front and back of this form. Once completed, please give to the receptionist. Thank you.

Client's Name: ____________________ ____________________ ____________________
First Middle Last

Date of Birth: ____________________ (mm/dd/yyyy) **Age** ________ **Weight** ________ **Height** ________

Sex of the Patient: **Female** ______ **Male** ______ **Other** ____________________

Names of Parents/Guardians: ____

Name/Relationship of Person Completing this Form: ____

Name of current school/program: ____

School grade: ____ **IEP/504 plan? If yes, please explain:** ____

Primary Care Physician's Name and Clinic: ____

Please state last appointment with a Primary Care Physician: ____

Preferred Pharmacy: ____

Are you currently being treated for any illness? If yes please explain:

____

Do you have any medical and/or surgical history? If yes please explain:

____

Are you currently taking any medications? If yes, please list name of medication and dose:

____

Turn Over To Complete Other Side

Please list all allergies and medication side effects: ________________________________

____

Do you, or anyone in your family, have a history of thyroid disorder___Yes___No. 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 <u>significant</u> 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.

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
IDSscr					
<u>When was the last time</u> you had <u>significant</u> problems…					
• 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
EDSscr					
<u>When was the last time</u> that you did the following things <u>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

(Continued) 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
SDSscr					
When was the last time that…					
• 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
CVSscr					
When was the last time that you…					
• 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

Staff Use Only

Number of 2's, 3's, and 4's: IDSscr: _____ EDSscr: _____ SDSscr: _____ CVSscr: _____ TDSscr: _____

Referral: _____ MH _____ SA _____ ANG _____ Other: ______________________

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Strengths and Difficulties Questionnaire

(P) or T 11-17

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

Signature .... Date ....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

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Strengths and Difficulties Questionnaire

S[11-17] *Client 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	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Your Signature ....

Today's Date ....

Thank you very much for your help

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