



**BRIGHTWATER HEALTH COMPREHENSIVE EVALUATION INTAKE —AGE 6 AND UP**

Thank you for your help in completing this questionnaire about your child. The information is necessary for our clinicians to gain a complete understanding of your concerns. Please let us know if you have any questions.

**IDENTIFYING INFORMATION:**

**Child's Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Preferred Pronouns:** She/Her He/Him They/Them **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Self-identified Gender:** \_\_\_\_\_ **Sexual Orientation:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ **Primary Language:** \_\_\_\_\_

**Ability to Read/Write?** Yes No **Special Accommodations:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

**Reason For Referral/What Is Bringing You In:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Life Stress Level:** High Medium Low

**Current Providers** (*Provider, provider location, date last seen, reason and frequency of care*)

Primary Care Provider \_\_\_\_\_  
Psychotherapist/CNP \_\_\_\_\_  
Psychotherapist \_\_\_\_\_  
Case Manager \_\_\_\_\_  
ARMHS \_\_\_\_\_  
Probation Officer \_\_\_\_\_  
Other \_\_\_\_\_

**DIMENSION I: Acute Risk or Acute Intoxication/Withdrawal Potential**

**Risk of Harm**

**Have you recently had thoughts or wishes to harm yourself?** No Yes, \_\_\_\_\_

**Have you recently had thoughts of harming others?** No Yes, \_\_\_\_\_

**Do you have a history of self-harm or suicide attempts?** No Yes, \_\_\_\_\_

**Substance Use**

No Yes To your knowledge, does your child currently use any alcohol or illegal substances?  
If yes, with what substances, when did they start, and how often used? \_\_\_\_\_

No  Yes Has your child ever attended substance abuse disorder treatment?  
If yes, where, and when? \_\_\_\_\_

No  Yes Does your child have any current or history of substance use withdrawal?  
If yes, what symptoms were experienced and when? \_\_\_\_\_

**DIMENSION II: Biomedical and Physical Health History**

**How would you rate your child's current physical health?**  Good  Fair  Poor

**Is your child experiencing any physical health concerns or have a current physical health diagnosis?** \_\_\_\_\_

**Has your child experienced any of the following? (Please provide comments):**

Traumatic Brain Injury: \_\_\_\_\_

Significant Illness That Affects Your Brain or Oxygen Level: \_\_\_\_\_

Exposure To A Sexually Transmitted or Blood Borne Diseases: \_\_\_\_\_

Nutritional Concerns: \_\_\_\_\_

Is your child/could they be pregnant?: \_\_\_\_\_

Physical Health Disability: \_\_\_\_\_

**Is your child suffering from any physical pain?**

No concerns with physical pain

Acute Pain (Identify Treatment Type Below)

Chronic Pain (Identify Treatment Type Below)

**If yes, Treatment Type:**

Prescribed Pain Medication  Home Remedies

Over the Counter Medication

Enrolled in Pain Management Program

Physical Therapy

Meditation  Medical Referral Needed

Other, Non-Pharmacological Approach

Not Being Treated

**Does your family engage in, or want to engage in, any cultural healing practices?**  No  Yes, \_\_\_\_\_

**Any Allergies:** \_\_\_\_\_

**Current Medications:** (Include OTC Medication and/or Herbal Supplements):

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Have you been prescribed mental health medications in the past?**  No  Yes

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Has your child had any prior surgeries or hospitalizations?**  No  Yes If yes, what, and when? \_\_\_\_\_

**FEMALE CLIENTS:** Age of Onset of Menstruation: \_\_\_\_\_

**Additional Comments Regarding Your Child's Current/Past Physical Health:**

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**SUBSTANCE USE HISTORY:**

Primary Substance Used	Age of First Use	Most Recent Pattern of Use and Duration:	Date/Time of Last Use	Withdrawal Potential? Needs special care?	Method of Use (Oral, Smoked, Snorted, IV, etc.)
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Crack					
Hallucinogens					
Heroin					
Inhalants					
Other Opiates/Synthetics					
Methamphetamine					
Nicotine					
Over the Counter Drugs					
Other					

**SUBSTANCE USE Withdrawal Symptoms:**

Symptom	Past 12 Months	Recent (Past 30 Days)
Agitation		
Anxiety/Worry		
Confused/Disrupted Speech		
Diarrhea		
Diminished Appetite		
Dizziness		
Fatigue/Extremely Tired		
Fever		
Hallucinations		
Headaches		
High Blood Pressure		
Irritability		
Muscle Aches		
Nausea/Vomiting		
Paranoia		
Psychosis		
Sad/Depressed Feeling		

Seizures		
Sensitivity to Noise		
Shakiness/Jitteriness/Tremors		
Sweating and Rapid Pulse		
Unable to Eat		
Unable to Sleep		
Vivid/Unpleasant Dreams		

Is there anything else you would like us to know regarding your child’s substance history or withdrawal symptoms?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIMENSION III: Emotional/Behavioral/Cognitive**

Parent’s Marital Status: Married Widowed Divorced Single Partnered Separated

	Name	Age	Occupation
Parent			
Parent			
Stepparent			
Stepparent			

What is the legal and physical custody arrangement? \_\_\_\_\_

**Others Living with Your Child/Siblings Living Outside the Home:**

Name	Age	Relationship	Occupation/Grade

**Pets:** \_\_\_\_\_

Who are the other important people in your child’s life (Relatives, mentors, coaches, family friends)? \_\_\_\_\_

\_\_\_\_\_

What is your child and family’s relationship with extended family? \_\_\_\_\_

\_\_\_\_\_

Has your child experienced any significant losses in your family? \_\_\_\_\_

\_\_\_\_\_

Does your child have a social support network that would support their recovery efforts? \_\_\_\_\_

\_\_\_\_\_

**Any developmental incidents?** Unremarkable Delayed Milestones Atypical Other \_\_\_\_\_

**EDUCATIONAL HISTORY:** Grade Level: \_\_\_\_\_ School Name: \_\_\_\_\_  
 Previous Education/Schools: \_\_\_\_\_  
 What has your child's experience been in school? \_\_\_\_\_

Does your child have behavioral, learning, or social problems at school?

No  Yes, \_\_\_\_\_

Does/has your child receive any special educational services (IEP, 504, Title 1) or have special educational needs?

No  Yes, \_\_\_\_\_

**FAMILY HISTORY:** Are there any relatives of the child (including parents, grandparents, aunts, uncles, or cousins who have any of the following conditions?

	Relationship		Relationship
ADHD/ADD		Eating Disorders	
Alcohol or Drug Problems		Learning Disorders	
Anxiety/OCD		Mental Health Hospitalizations	
Autism/Autism Spectrum Disorder		Nerve Problems	
Bipolar Disorder		Personality Disorders	
Brain Damage		Physical Abuse	
Chronic Pain		PTSD	
Completion of or Suicide Attempts		Schizophrenia	
Convulsions/Seizures		School Problems	
Dementia		Sexual Abuse	
Depression		Thyroid Problems	
Developmental Delays		Tic/Tourette's Disorder	
Domestic Violence		Other	

**PAST MENTAL HEALTH SERVICES:**

AHRMS/Case Management Services: \_\_\_\_\_  
 CTSS/Case Management Services: \_\_\_\_\_  
 Mental Health/Substance Use Hospitalizations: \_\_\_\_\_  
 Partial Hospitalization Program: \_\_\_\_\_  
 Previous Mental Health Diagnosis: \_\_\_\_\_  
 Psychiatric Care: \_\_\_\_\_  
 Psychological Testing: \_\_\_\_\_  
 Psychotherapy: \_\_\_\_\_  
 Other: \_\_\_\_\_

**CHILDHOOD LIFE EVENTS:** Below is a list of events that may occur in a child's life. Please check any events that you know or suspect your child has experienced.

X if Yes	Age	Event	Other Information
		Bullying	
		Emotional Abuse	
		Exposure to Adult Substance Use	
		Exposure to Domestic Violence	
		Exposure to Sexual Material	
		Frequent Moves	

	Homelessness	
	House Fire	
	Impaired Parenting (Due to parental mental health issues, substance use, etc)	
	Major Medical Procedure or Surgeries	
	Major Natural Disaster (Flood, tornado)	
	Multiple Separations from Caregiver (Military deployments, working away from home)	
	Other Scary or Dangerous Event	
	Periods of Time When Adults Were Unable to Care for Them	
	Physical Abuse	
	Serious Car Accident	
	Sexual Abuse	
	Sexual Harassment	
	Unexpected Death of a Close Relative	
	Witnessed Others Being Physically Abused	
	Other Traumatic Events	

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

**CURRENT SYMPTOMS**

Please check the follow symptoms you are currently seeing for your child and elaborate on how often and long this has been a problem.

**Addictive Behavior**

Check if Applies	Symptom	Describe (Include how long and how often)
	Computer/Gaming	
	Exercise/Fitness	
	Gambling	
	Sexual Activity	
	Shopping/Spending	
	Other	

**Anxiety**

Check if Applies	Symptom	Describe (Include how long and how often)
	Compulsive Behaviors	
	Disorganized Speech	
	Excessive shyness	
	Fearfulness	
	Stomachache/Pain/Headache	
	Intrusive Thoughts	
	On edge/Restless	
	Racing Thoughts	
	Social Fears	
	Unassertive	
	Withdrawn	

	Worries/anxiety	
	Other	

**Behavior and Attention**

Check if Applies	Symptom	Describe (Include how long and how often)
	Aggressive Behavior	
	Completes Tasks Carelessly	
	Concentration Problems	
	Destroys Own/Others' Possessions	
	Disorganized/Forgetful	
	Distracts/Annoys Others	
	Does Not Notice When They Make Mistakes	
	Focus' Too Much (In their own world)	
	Gets Stuck or Perseverates on Certain Things	
	Has Difficulty Following Directions (School, home, in public)	
	Having Too Much Energy/Cannot Sit Still	
	Impulse Control	
	Lies/Omits Information/Does Not Tell the Truth	
	Mean to Animals	
	Peer/Social Problems	
	Plays with Fire/Matches	
	Poor Judgment About Safety	
	Running Away	
	Takes Things That Do Not Belong to Them	
	Other	

**Eating**

Check if Applies	Symptom	Describe (Include how long and how often)
	Appetite/Weight Changes	
	Hoards/Hides/Sneaks Food	
	Is dieting	
	Makes Comments About Needing to Lose Weight or Being Fat	
	Other	

**Mood**

Check if Applies	Symptom	Describe (Include how long and how often)
	Changed Groups of Friends	
	Changed Level of Energy	
	Easily Irritated	
	Hygiene Concerns	

	Lacks Interest in Activities They Use to Enjoy	
	Mood Swings/Emotional lability (Fine one minute, mad/sad the next)	
	Morbid (Talking about death)	
	Negative Thoughts/Beliefs About Self	
	Personality Changes	
	Sadness	
	Seeing, Feeling, Tasting, Smelling or Hearing Things That Are Not There	
	Self-Harming Behavior (Cutting, erasing self, punching walls, etc.)	
	Socially Withdrawn	
	Suicidal Threats	
	Tearfulness/Cries Easily	
	Unusual/Bizarre Ideas	
	Other	

**Sleep**

Check if Applies	Symptom	Describe (Include how long and how often)
	Difficulty Getting Up	
	Nightmares	
	Problems Falling Asleep	
	Problems Staying Asleep	
	Other	

How many hours of sleep does your child typically get a night? \_\_\_\_\_  
 What time is their bedtime during the week? \_\_\_\_\_ When do they usually get up? \_\_\_\_\_  
 Does your child fall asleep by themselves or with someone else? \_\_\_\_\_

**Trauma**

Check if Applies	Symptom	Describe (Include how long and how often)
	Avoidance of Memories, Places or People	
	Does Not Appear to Experience Positive Emotions	
	Intrusive Thoughts or Memories	
	Jumpy/Startles Easily	
	Poor Recall or Memory of Events	
	Other	

**Are there any other symptoms or issues that you think would be helpful for us to know about?**  
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 \_\_\_\_\_

**DIMENSION IV: Readiness for Change**

What has helped your child in the past? What has not worked? \_\_\_\_\_  
 \_\_\_\_\_

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What would be helpful for you and your child in making changes? \_\_\_\_\_

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**DIMENSION V: Relapse, Continue Use/Problem Potential**

What would you identify as your child's strengths?

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What would you identify as your child's personal challenges?

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**DIMENSION VI: Recovery Environment**

**Child's Current Living Situation**

Any safety concerns in your current living environment? No Yes

Please describe the home in which your child resides (*Include length of residency, household members or status of current housing*) \_\_\_\_\_

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**EMPLOYMENT/FINANCIAL**

Is your child currently employed or do they have any job history? \_\_\_\_\_

Any difficulties accessing services or meeting your basic needs: \_\_\_\_\_

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Current Financial Difficulties or Strain: \_\_\_\_\_

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**LEGAL**

Have you in the past, or are you currently working with Child Protective Services? No Yes

*Please provide details on social workers involved, dates of involvement, etc.* \_\_\_\_\_

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Has your child been arrested or had any legal interactions? No Yes \_\_\_\_\_

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Is your child currently on probation and/or involved with a specialty court program? No Yes

*Please provide details on probations officers name, dates of involvement, etc.*

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**CULTURAL/SPIRITUAL**

Do you have any spiritual, or other types of belief systems, that are important to your child's recovery?

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Do you have any cultural practices that are important for your child's recovery?

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**Thank you for taking the time to fill out this questionnaire.**