



# Comprehensive Holistic Health & House Calls

Division of Holzer Enterprises

**Lynne Odell-Holzer, MSN, FNP, NPP**

Registered Nurse Practitioner in Family Medicine & Psychiatry

7751 Treadmill Circle

Liverpool, NY 13090

315-622-9241 Voice & Fax

315-506-0015 Urgent Only

hhh@holzerent.com

## YOUR MEDICATION RECORD

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

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Allergies (Foods, Environmental, Drugs): \_\_\_\_\_

Record any vitamins, supplements, herbal preparations, homeopathic remedies, and Over-The-Counter Medications:

Medication Name	Generic Name	Purpose	Dose and How Often I Take It	Prescriber's Name	Prescriber's Number
--------------------	-----------------	---------	---------------------------------	----------------------	------------------------

1. \_\_\_\_\_
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### How to Avoid Medication Accidents

*In the United States, one person dies each day and 1.3 million people are injured annually due to medication errors.  
To ensure your own safety, here are some tips to follow:*

- ◆ Get in the habit of locking all prescribed, over-the-counter medications, herbal and vitamin preparations in a metal lockbox. Many medication injuries are accidental ingestion by children or pets, or suicide attempts by distraught people.
- ◆ Tell your prescriber about adverse reactions you have had to medications, foods, or other substances. Sometimes these non-medication substances have derivatives in the vehicle substances the medication is in.
- ◆ Make your prescriber and pharmacist aware of drug allergies.
- ◆ Make a list of your prescription, over-the-counter, herbal and vitamin supplements. This will alert your prescriber and pharmacist to any possible interactions and will come in handy in case of an emergency.
- ◆ Bring a notepad to health care visits. Note the exact spelling of the medications you are prescribed. Many medications have similar spellings and could be easily mistaken by the pharmacist.
- ◆ Watch punctuation. If the decimal point is not visible, 5.0 mg. can be easily misread as 50 mg. which is ten times the proper dose.
- ◆ Read labels carefully to ensure that the name of the medicine dispensed matches what you wrote down in your prescriber's office.
- ◆ If the size, color, shape, markings, or consistency of a medication differs from the medication you typically take, show it to your pharmacist before taking it.
- ◆ Ask for and write down your prescriber's instructions about medication frequency and any other precautions about food, activities, alcohol, and driving.
- ◆ Make certain you receive and understand printed information about your medication from your pharmacist. It will alert you to any possible side effects or interactions.
- ◆ Store medications in their original bottles; dispense a week's supply in a four-compartment pillbox with morning, noon, evening, and bedtime compartments to avoid mistakes, such as taking nighttime sleep medications before your morning drive.
- ◆ If you have an adverse reaction to a new supply of your medication, call your prescriber or pharmacist immediately.
- ◆ Do not store family members' medications all in a jumble in the locked box. Consider grouping or color coding the medication containers for easier identification.
- ◆ Discard expired or unused medications.
- ◆ Use of some medications may require periodic blood, liver, or kidney tests. Be aware of whether the drugs you are taking require such test, and, if so, remind your prescriber when these tests are due.
- ◆ Ask your prescriber for both the brand name and generic name of all drugs prescribed so you can confirm that you are receiving the correct medication.
- ◆ Read the label of ingredients of any over-the-counter medications you may consider taking. Many of them have the same few medications in different quantities. Some of these medications may also have been prescribed for a similar condition and taking both the prescription and over-the-counter drugs may cause an accidental overdose.



## Patient Information

# Preventing Adverse Drug Reactions

### Additional Notes:

***Prescription drugs are supposed to make you feel better, but in some cases they can make you feel worse.***

On average, 360 people die each day because of adverse drug events—a rare reaction a person may experience if he takes a prescription incorrectly. Adverse drug events also can occur when drugs interact with other drugs or with certain foods. Often, adverse drug events happen because of poor communication between patients and their clinicians or pharmacists.

### ***Protect yourself by sharing information.***

Since you will receive a prescription about 75% of the time you visit your health care provider, you should ensure that you are not at risk for an adverse drug event. If you take five or more prescriptions, you need to be especially careful to tell your clinician and pharmacist all of the drugs you take, since you are at the highest risk for experiencing an adverse drug event.

### ***Tips to make sure you use your medications safely and effectively:***

- Know your medicines. This means prescription and over-the-counter medicines, including vitamins and herbal remedies. If you go to several health care providers or pharmacists, make sure you tell each of them what drugs you take.
- Know your medical history. Keep a detailed record of all of your surgeries, hospitalizations, immunizations, allergies and your family's history of illnesses or diseases. Also, tell your health care provider if there are any changes in your life, such as if you are now working night shift or are on a special diet. Let your health care provider know if you are pregnant or breastfeeding, or if you plan to. Additionally, let her know if you suspect you might have had an adverse drug event in the past.
- Ask about a drug's side effects. If you think you're experiencing any unusual effects that you weren't told about, call your health care provider or pharmacist *immediately*. Read any package inserts or pamphlets you were given with the drug—they, too, will list side effects.
- Follow prescription directions. Ask your health care provider or pharmacist how often and how long you should take your prescription, and follow the directions provided. Taking too much of a drug can cause an adverse drug event, and taking too little of a drug or stopping it before you're supposed to can provide little benefit to your health. Don't start taking new over-the-counter drugs unless you ask your health care provider or pharmacist first.
- Keep a personal medication record. Write down the medication name, whether it's available by prescription or over the counter, how and how often you should take the medication, the date it was prescribed to you, the health care provider who prescribed it to you (and his phone number), and your pharmacist's name and phone number. Also write down why you are taking the drug and any side effects you experience when on the drug.

### ***Communication reduces risk.***

When you, your health care provider and pharmacist communicate about your prescriptions, your diet, your health and your lifestyle, you will greatly reduce your chances of experiencing an adverse drug event. Taking drugs responsibly is more than just swallowing a pill, it's also using your good common sense.

*Information adapted from Ortho-McNeil Pharmaceutical Inc.'s Web site "Prescription for Safety" at <http://www.prescriptionforsafety.com>.*

*Your nurse practitioner has given you this patient education handout to further explain or remind you about principles related to your medical condition. This handout is a general guide only. If you have specific questions, be sure to discuss them with your nurse practitioner.*

**CHHHC HEDIS Tracking—Name:** \_\_\_\_\_

Test/Screen	Provider	Telephone	Date	Date	Date	Date	Date
Eye Exam							
GYNGU Exam							
Mammogram							
TSE/BSE							
Colonoscopy							
Dental Exam							
Flu Vaccine							
Pneumonia							
Tetanus							
Hepatitis B							
All Other Vaccines							
Helmets							
Seatbelts							
Loading Meds							
Guns/Weapons							
Substances:							
ETOH							
Nicotine							
THC							
Crack							
Speed							
Hallucinogens							
Others							
Diet Education							
Hi-Risk Sports							
Exercise Habits							
Sleep Habits							
Last H & P							
Domestic Violence							
BMI							



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## PRECURSORS FOR ESTIMATING CAPACITY FOR THERAPEUTIC CHANGE

Patient: \_\_\_\_\_ DATE: \_\_\_\_\_ Evaluator: \_\_\_\_\_

Precursor & Its Markers	None (0)	Trace (1)	Small (2)	Adequate (3)	Abundant (4)
<b>Sense of necessity</b> Expresses desire for change Feels a sense of urgency					
<b>Readiness for anxiety</b> Openness to experience Likely to take risks					
<b>Awareness</b> Able to identify problems Identifies thoughts, feelings					
<b>Confronting the problem</b> Courageously faces problems Sustained attention to issues					
<b>Effort or will toward change</b> Eagerly does homework High energy; active cooperation					
<b>Hope for change</b> Positive outlook; open to future High coping; therapeutic humor					
<b>Social support for change</b> Wide network of friends & family Many confiding relationships					

**TOTAL SCORE:**

### Scoring Guide\*

- 0-6: Change unlikely. Educate client on change. Focus on precursors with lowest ratings.
- 7-14: Change limited or erratic. Educate client & focus on precursors with lowest ratings.
- 15-21: Change is steady & noticeable. Use the lowest rated precursors to stay on track.
- 22-28: Highly motivated & inspired client. Change occurs easily. Standard approaches work well.

\*Scoring is intended only as a general guide to a complex process.  
Some precursors may be more potent.

From: "Precursors of Change: Pivotal Points of Involvement & Resistance in Psychotherapy"  
F. J. Hana, 1996, *J of Psychotherapy Integration* 6, p 248. Plenum Publishing

# HAMILTON DEPRESSION SCALE

NAME \_\_\_\_\_

DATE OF  
BIRTH \_\_\_\_\_

DATE \_\_\_\_\_

**Formedic**

## 1. DEPRESSED MOOD

(Sadness, hopelessness, helplessness, worthlessness)

- 0 = Absent
- 1 = These feeling states indicated only on questioning
- 2 = These feeling states spontaneously reported verbally
- 3 = Communicates feeling states non-verbally - i.e., through facial expression, posture, voice, and tendency to weep
- 4 = Patient reports VIRTUALLY ONLY these feeling states in his own spontaneous and non-verbal communication ☐

## 2. FEELINGS OF GUILT

- 0 = Absent
- 1 = Self-reproach, feels he has let people down
- 2 = Ideas of guilt or rumination over past errors or sinful deeds
- 3 = Present illness is a punishment. Delusions of guilt
- 4 = Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations ☐

## 3. SUICIDE

- 0 = Absent
- 1 = Feels life is not worth living
- 2 = Wishes he were dead or any possible death to self
- 3 = Suicide ideas or gesture
- 4 = Attempts at suicide (any serious attempt rates 4) ☐

## 4. INSOMNIA EARLY

- 0 = No difficulty falling asleep
- 1 = Complains of occasional difficulty falling asleep - i.e., more than 1/2 hour
- 2 = Complains of nightly difficulty falling asleep ☐

## 5. INSOMNIA MIDDLE

- 0 = No difficulty
- 1 = Patient complains of being restless and disturbed during the night
- 2 = Waking during the night - any getting out of bed rates 2 (except for purpose of voiding) ☐

## 6. INSOMNIA LATE

- 0 = No difficulty
- 1 = Waking in early hours of the morning but goes back to sleep
- 2 = Unable to fall asleep again if he gets out of bed ☐

COLUMN SCORE

## 7. WORK AND ACTIVITIES

- 0 = No difficulty
- 1 = Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies
- 2 = Loss of interest in activity; hobbies or work - either directly reported by patient or indirectly in listlessness, indecision and vacillation (feels he has to push self to work or activities)
- 3 = Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities (hospital, job or hobbies) exclusive of ward chores
- 4 = Stopped working because of present illness. In hospital, rate 4, if patient engages in no activity except ward chores, or if patient fails to perform ward chores unassisted ☐

## 8. RETARDATION

(Slowness of thought and speech; impaired ability to concentrate; decreased activity)

- 0 = Normal speech and thought
- 1 = Slight retardation at interview
- 2 = Obvious retardation at interview
- 3 = Interview difficult
- 4 = Complete stupor ☐

## 9. AGITATION

- 0 = None
- 1 = "Playing with" hands, hair, etc.
- 2 = Hand wringing, nail-biting, hair pulling, biting of lips ☐

## 10. ANXIETY PSYCHIC

- 0 = No difficulty
- 1 = Subjective tension and irritability
- 2 = Worrying about minor matters
- 3 = Apprehensive attitude apparent in face or speech
- 4 = Fears expressed without questioning ☐

## 11. ANXIETY SOMATIC

- 0 = Absent
  - 1 = Mild
  - 2 = Moderate
  - 3 = Severe
  - 4 = Incapacitating
- Physiological concomitants of anxiety such as:
- Gastrointestinal - dry mouth, wind, indigestion, diarrhea, cramps, belching
  - Cardiovascular - palpitations, headaches
  - Respiratory - hyperventilation, sighing
  - Urinary frequency
  - Sweating ☐

## 12. SOMATIC SYMPTOMS GASTROINTESTINAL

- 0 = None
- 1 = Loss of appetite but eating without staff/family encouragement. Heavy feelings in abdomen
- 2 = Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for G.I. symptoms ☐

COLUMN SCORE

**PROVIGIL helps patients stay  
AWAKE, ALERT, and ENGAGED**

Please see reverse side for important safety information; see full prescribing information on last pages of pad.



**PROVIGIL®**  
(MODAFINIL)   
Tablets

## 13. SOMATIC SYMPTOMS GENERAL

- 0 = None  
 1 = Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy, easily fatigued  
 2 = Any clear-cut symptom rates 2

☐

## 14. GENITAL SYMPTOMS

- 0 = Absent      Symptoms such as: Loss of libido  
 1 = Mild                      Menstrual  
 2 = Severe                      disturbances

☐

## 15. HYPOCHONDRIASIS

- 0 = Not present  
 1 = Self-absorption (bodily)  
 2 = Preoccupation with health  
 3 = Frequent complaints, requests for help, etc.  
 4 = Hypochondriacal delusions

☐16. LOSS OF WEIGHT (rate either a or b)

## a. When rating by history:

- 0 = No weight loss  
 1 = Probable weight loss associated with present illness  
 2 = Definite (according to patient) weight loss  
 3 = Not assessed

☐

## b. On a weekly ratings by ward psychiatrist, when actual weight changes are measured:

- 0 = Less than 1 lb. weight loss in one week  
 1 = Greater than 1 lb. weight loss in one week  
 2 = Greater than 2 lb. weight loss in one week  
 3 = Not assessed

☐

COLUMN SCORE

## 17. INSIGHT

- 0 = Acknowledges being depressed and ill  
 1 = Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.  
 3 = Denies being ill at all

☐

## 18. DIURNAL VARIATION

- a. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark one

- 0 = No variation  
 1 = Worse in A.M.  
 2 = Worse in P.M.

☐

- b. When present, mark the severity of the variation. Mark "None" if NO variation

- 0 = None  
 1 = Mild  
 2 = Severe

☐

## 19. DEPERSONALIZATION AND DEREALIZATION

- 0 = Absent      Such as: Feelings of unreality  
 1 = Mild                      Nihilistic ideas  
 2 = Moderate  
 3 = Severe  
 4 = Incapacitating

☐

## 20. PARANOID SYMPTOMS

- 0 = None  
 1 = Suspicious  
 2 = Ideas of reference  
 3 = Delusions of reference and persecution

☐

## 21. OBSESSIVE AND COMPULSIVE SYMPTOMS

- 0 = None  
 1 = Mild  
 2 = Severe

☐

COLUMN SCORE

TOTAL SCORE

## ADDITIONAL NOTES

## NEXT APPOINTMENT

PROVIGIL is indicated to improve wakefulness in patients with excessive sleepiness (ES) associated with narcolepsy, obstructive sleep apnea/hypopnea syndrome (OSAHS), and shift work sleep disorder (SWSD).

In OSAHS, PROVIGIL is indicated as an adjunct to standard treatment(s) for the underlying obstruction.

## Important Safety Information

Patients with abnormal levels of sleepiness who take PROVIGIL should be advised that their level of wakefulness

may not return to normal. Patients with excessive sleepiness, including those who take PROVIGIL, should be frequently reassessed for their degree of sleepiness and, if appropriate, advised to avoid potentially dangerous activities.


In clinical trials, PROVIGIL was generally well tolerated. The most frequently reported adverse events (≥5%) were headache, nausea, nervousness, phytitis, diarrhea, back pain, anxiety, insomnia, dizziness, and dyspepsia. Most adverse events were mild to moderate. PROVIGIL

may interact with drugs that inhibit, induce, or alter metabolism and cytochrome P450 isoenzymes.

For more information, visit [www.PROVIGIL.com](http://www.PROVIGIL.com) or call 1-800-895-5655.

Please see full prescribing information for PROVIGIL on last pages of pack.

**PROVIGIL®**  
 (MODAFINIL)   
 Tablets

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Symptom Tracking---Name: \_\_\_\_\_

[illegible]



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## Thoughtful Questions

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Please fill in the rest of the sentence with whatever seems the most appropriate to you at the time. There are no right or wrong answers. This is geared to evaluate your current mood and has no diagnostic or other evaluation purpose. Feel free to ask any questions you may have during this process.

1. I like people who.....
2. Mom was.....
3. When people try to boss me.....
4. As a child.....
5. I get angry when.....
6. What worries me.....
7. The trouble with women.....
8. Most of all, I want to.....
9. I am ashamed.....
10. They.....
11. A good person.....
12. The trouble with my home.....
13. I dislike people who.....
14. When I was a kid, I liked.....
15. I can't stand it when.....
16. I am afraid .....
17. Compared to women, men.....
18. I used to wish.....
19. If I do something wrong.....
20. I am .....
21. A good friend.....
22. The important fact about my dad.....
23. I don't like people who.....
24. When I was young, my greatest trouble.....
25. I might lose self-control.....

26. I need.....
27. It is wrong.....
28. God is.....
29. If people praise me.....
30. A sister.....
31. If someone tells me, "You can't do it.".....
32. When I went to school.....
33. I could kill someone if.....
34. I feel tense when.....
35. The worst thing a man could do to a woman.....
36. The most important thing in my life was.....
37. You get punished for.....
38. Death.....
39. When people trust me.....
40. A brother.....
41. When I am criticized.....
42. My favorite game, as a kid.....
43. I hate.....
44. I can't think right when.....
45. Love.....
46. I should like.....
47. I wish I had not.....
48. Life.....
49. When my mom.....
50. Someday I.....

**FAMILY AND PERSONAL HEALTH HISTORY**

**Note:** Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Last Physical Examination Date \_\_\_\_\_ Daytime Phone \_\_\_\_\_

<b>FAMILY RECORD</b>							<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Date
Check (✓) condition(s) and relationship of any blood relative who has or has had any of the conditions listed below.									
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Birth Defects									
Bleeding Tendency									
Cancer, tumor									
Colitis									
Congenital Heart									
Diabetes									
Emphysema									
Epilepsy									
Glaucoma									
Goiter									
Hay Fever									
Heart Attack									
Heart Disease									
High Blood Pressure									
Kidney Disease									
Leukemia									
Liver Disease									
Mental Illness									
Migraine									
Nervous Breakdown									
Obesity									
Rheumatism									
Rheumatic Fever									
Sickle-Cell Anemia									
Stomach Ulcer									
Stroke									
Suicide									
Tuberculosis									
<b>FAMILY MEMBERS</b>									
<b>Living</b>						<b>Deceased</b>			
	Age	Health			Cause of Death				
		Good	Fair	Poor					
Father									
Mother									
Brother(s)									
Sister(s)									
<b>OPERATIONS</b>									
Tonsils									
Appendix									
Gall Bladder									
Stomach									
Kidney									
Colon									
Thyroid									
Hernia									
Breast (women)									
Uterus (women)									
Ovaries (women)									
Prostate (men)									
Other - If yes, what:									
<b>Do You:</b> If yes, daily consumption:									
Smoke						Pkgs.			
Drink Coffee						Cups			
Beer						ozs.			
Hard liquor						ozs.			
<b>IMMUNIZATIONS</b>									
Pneumonia Vaccine									
Tetanus									
Booster									
Measles									
Influenza									
German Measles/Mumps									
Other - If yes, what:									
<b>X-RAYS</b>									
When was last mammogram?									
Back									
Chest									
Colon									
Extremities									
Gall Bladder									
Kidney									
Stomach									
Treatments									
Other - If yes, what:									
<b>Doctor's Use Only — Summary</b>									

# PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date	Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Asthma					Skin Disease				
Abnormal Electrocardiogram					Serious Depression				
Angina					Serious Emotional Problems				
Anemia (Type )					Tuberculosis				
Arthritis					Thyroid (overactive)				
Blindness Either Eye					Thyroid (underactive)				
Broken Bones					Varicose Veins				
Cataracts					<b>Men</b>				
Chronic Bronchitis/Chronic Lung Disease					Prostate Problems				
Cirrhosis of Liver					<b>Women</b>				
Colon or Bowel Trouble					Menstrual Difficulties				
Deafness					Cystitis				
Dysentery					Mastitis				
Diabetes					Ovarian Cyst				
Ear Infections					Breast Cancer				
Emphysema					Other Breast Disease*				
Enlarged Heart					Other Gynecological Problems*				
Glaucoma					Still Menstruating				
Gall Stones					Age Period Started				
Gout					Age Periods Stopped				
Goiter					Why Periods Stopped				
Gonorrhea					Number of Pregnancies				
Hay Fever					Number of Children				
Heart Murmur as Adult					Number of Miscarriages				
Heart Attack					*Explain:				
High Blood Pressure									
Hepatitis									
Hemorrhoids									
Kidney Infection					Hospitalizations/Reason	Date			
Kidney Stones									
Nervous Breakdown									
Poor Blood Clotting									
Polio					Do you wear artificial devices?	Yes	No		
Phlebitis					Please list				
Rheumatic Fever									
Rectal Trouble									
Recurrent Boils					Do you have allergies?	Yes	No		
Stroke					Please list				
Stomach or Duodenal Ulcer									
Syphilis									

Doctor's Use Only — Summary

--	--	--	--	--	--	--	--	--	--

Patient's Name: \_\_\_\_\_

Medicare # (HICN): \_\_\_\_\_

## ADVANCE BENEFICIARY NOTICE (ABN)

**NOTE:** You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for –

**Items or Services:** Approximately 50% of your mental health visits costs as well as any annual deductibles.

**Because:** Federal regulations. This will mean you are responsible for approximately \$45.00-\$70.00 per visit. You may have supplemental insurance that reduces this expense typically \$10.00-\$15.00 per visit.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay. **See Above.**
- Ask us how much these items or services will cost you (Estimated Cost: \$ \_\_\_\_\_), in case you have to pay for them yourself or through other insurance.

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.**

☐ **Option 1. YES.** I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO.** I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf

**NOTE:** Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

## Client Information

ID \_\_\_\_\_

Today's date \_\_\_\_\_

Your name \_\_\_\_\_

Your age \_\_\_\_\_

Male ☐ Female ☐

Your marital status \_\_\_\_\_

Your race/ethnic group \_\_\_\_\_

Highest level of  
education \_\_\_\_\_

## Instructions

The purpose of this questionnaire is for you to describe the kind of person you are. When answering the questions, think about how you have tended to feel, think, and *act over the past several years*. To remind you of this, on the top of each page you will find the statement: "**Over the past several years...**"

Please answer either **True** or **False** to each item.

Where:

T (True) means that the statement is generally true for you.

F (False) means that the statement is generally false for you.

Even if you are not entirely sure about the answer, indicate "T" or "F" for every question.

For example, for the question:

xx. I tend to be stubborn.

T      F

If, in fact you have been stubborn over the past several years, you would answer True by circling T.

If, this was not true at all for you, you would answer False by circling F.

There are no correct answers.

You may take as much time as you wish.

## Over the past several years...

- |   |   |   |
|---|---|---|
| 1. I avoid working with others who may criticize me.  | T | F |
| 2. I can't make decisions without the advice, or reassurance, of others.                      | T | F |
| 3. I often get lost in details and lose sight of the "big picture."                           | T | F |
| 4. I need to be the center of attention.  | T | F |
| 5. I have accomplished far more than others give me credit for.                               | T | F |
| 6. I'll go to extremes to prevent those who I love from ever leaving me.                      | T | F |
| 7. Others have complained that I do not keep up with my work or commitments.                  | T | F |
| 8. I've been in trouble with the law several times (or would have been if I had been caught). | T | F |
| 9. Spending time with family or friends just doesn't interest me.                             | T | F |
| 10. I get special messages from things happening around me.                                   | T | F |
| 11. I know that people will take advantage of me, or try to cheat me, if I let them.          | T | F |
| 12. Sometimes I get upset.  | T | F |



- |  |   |   |
|--|---|---|
| 13. I make friends with people only when I am sure they like me.                     | T | F |
| 14. I am usually depressed.  | T | F |
| 15. I prefer that other people assume responsibility for me.                         | T | F |
| 16. I waste time trying to make things too perfect.                                  | T | F |
| 17. I am "sexier" than most people.  | T | F |
| 18. I often find myself thinking about how great a person I am, or will be.          | T | F |
| 19. I either love someone or hate them, with nothing in between.                     | T | F |
| 20. I get into a lot of physical fights.   | T | F |
| 21. I feel that others don't understand or appreciate me.                            | T | F |
| 22. I would rather do things by myself than with other people.                       | T | F |
| 23. I have the ability to know that some things will happen before they actually do. | T | F |
| 24. I often wonder whether the people I know can really be trusted.                  | T | F |
| 25. Occasionally I talk about people behind their backs.                             | T | F |

- |   |   |   |
|---|---|---|
| 26. I am inhibited in my intimate relationships because I am afraid of being ridiculed. | T | F |
| 27. I fear losing the support of others if I disagree with them.                        | T | F |
| 28. I have many shortcomings.   | T | F |
| 29. I put my work ahead of being with my family or friends or having fun.               | T | F |
| 30. I show my emotions easily.  | T | F |
| 31. Only certain special people can really appreciate and understand me.                | T | F |
| 32. I often wonder who I really am.   | T | F |
| 33. I have difficulty paying bills because I don't stay at any one job for very long.   | T | F |
| 34. Sex just doesn't interest me.   | T | F |
| 35. Others consider me moody and "hot tempered."  | T | F |
| 36. I can often sense, or feel things, that others can't.                               | T | F |
| 37. Others will use what I tell them against me.  | T | F |
| 38. There are some people I don't like.   | T | F |

- |  |   |   |
|--|---|---|
| 39. I am more sensitive to criticism or rejection than most people.        | T | F |
| 40. I find it difficult to start something if I have to do it by myself.   | T | F |
| 41. I have a higher sense of morality than other people.                   | T | F |
| 42. I am my own worst critic.  | T | F |
| 43. I use my "looks" to get the attention that I need.                     | T | F |
| 44. I very much need other people to take notice of me or compliment me.   | T | F |
| 45. I have tried to hurt or kill myself.                                   | T | F |
| 46. I do a lot of things without considering the consequences.             | T | F |
| 47. There are few activities that I have any interest in.                  | T | F |
| 48. People often have difficulty understanding what I say                  | T | F |
| 49. I object to supervisors telling me how I should do my job.             | T | F |
| 50. I keep alert to figure out the real meaning of what people are saying. | T | F |
| 51. I have never told a lie.   | T | F |

- |  |   |   |
|--|---|---|
| 52. I am afraid to meet new people because I feel inadequate.                                  | T | F |
| 53. I want people to like me so much that I volunteer to do things that I'd rather not do.     | T | F |
| 54. I have accumulated lots of things that I don't need but I can't bear to throw out.         | T | F |
| 55. Even though I talk a lot, people say that I have trouble getting to the point.             | T | F |
| 56. I worry a lot.   | T | F |
| 57. I expect other people to do favors for me even though I do not usually do favors for them. | T | F |
| 58. I am a very moody person.  | T | F |
| 59. Lying comes easily to me and I often do it.  | T | F |
| 60. I am not interested in having close friends.   | T | F |
| 61. I am often on guard against being taken advantage of.                                      | T | F |
| 62. I never forget, or forgive, those who do me wrong.   | T | F |
| 63. I resent those who have more "luck" than I.  | T | F |

- |   |   |   |
|---|---|---|
| 64. A nuclear war may not be such a bad idea.                                     | T | F |
| 65. When alone, I feel helpless and unable to care for myself.                    | T | F |
| 66. If others can't do things correctly, I would prefer to do them myself.        | T | F |
| 67. I have a flair for the dramatic.  | T | F |
| 68. Some people think that I take advantage of others.                            | T | F |
| 69. I feel that my life is dull and meaningless.                                  | T | F |
| 70. I am critical of others.  | T | F |
| 71. I don't care what others have to say about me.                                | T | F |
| 72. I have difficulties relating to in a one-to-one situation.                    | T | F |
| 73. People have often complained that I did not realise that they were upset.     | T | F |
| 74. By looking at me, people might think that I'm pretty odd, eccentric or weird. | T | F |
| 75. I enjoy doing risky things.   | T | F |
| 76. I have lied a lot on this questionnaire.                                      | T | F |
| 77. I complain a lot about my hardships.  | T | F |

- |   |   |   |
|---|---|---|
| 78. I have difficulty controlling my anger, or temper                                     | T | F |
| 79. Some people are jealous of me.  | T | F |
| 80. I am easily influenced by others.   | T | F |
| 81. I see myself as thrifty but others see me as being cheap.                             | T | F |
| 82. When a close relationship ends, I need to get involved with someone else immediately. | T | F |
| 83. I suffer from low self-esteem.  | T | F |
| 84. I am a pessimist.   | T | F |
| 85. I waste no time in getting back at people who insult me.                              | T | F |
| 86. Being around other people makes me nervous.   | T | F |
| 87. In new situations, I fear being embarrassed.  | T | F |
| 88. I am terrified of being left to care for myself.                                      | T | F |
| 89. People complain that I'm "stubborn as a mule."  | T | F |
| 90. I take relationships more seriously than do those who I'm involved with.              | T | F |

- |   |   |   |
|---|---|---|
| 91. I can be nasty with someone one minute, then find myself apologizing to them the next minute. | T | F |
| 92. Others consider me to be stuck up.  | T | F |
| 93. When stressed, things happen. Like I get paranoid or just "black out."                        | T | F |
| 94. I don't care if others get hurt so long as I get what I want.                                 | T | F |
| 95. I keep my distance from others.   | T | F |
| 96. I often wonder whether my wife (husband, girlfriend, or boyfriend) has been unfaithful to me. | T | F |
| 97. I often feel guilty   | T | F |
| 98. I have done things on impulse (such as those below ✕) that could have gotten me into trouble. | T | F |

*If you answered true, please check all that apply to you:*

- |   |                          |
|---|--------------------------|
| a. Spending more money than I have      | <input type="checkbox"/> |
| b. Having sex with people I hardly know | <input type="checkbox"/> |
| c. Drinking too much                    | <input type="checkbox"/> |
| d. Taking drugs                         | <input type="checkbox"/> |
| e. Eating binges                        | <input type="checkbox"/> |
| f. Reckless driving                     | <input type="checkbox"/> |

99. When I was a kid (before age 15), I was somewhat of a juvenile delinquent, doing some of the things below.

T F

Now, Check ☒ all that apply to you:

- |  |                          |
|--|--------------------------|
| (1) I was considered a bully. ....                               | <input type="checkbox"/> |
| (2) I used to start fights with other kids. ....                 | <input type="checkbox"/> |
| (3) I used a weapon in fights that I had. ....                   | <input type="checkbox"/> |
| (4) I robbed or mugged other people. ....                        | <input type="checkbox"/> |
| (5) I was physically cruel to other people. ....                 | <input type="checkbox"/> |
| (6) I was physically cruel to animals. ....                      | <input type="checkbox"/> |
| (7) I forced someone to have sex with me. ....                   | <input type="checkbox"/> |
| (8) I lied a lot. ....   | <input type="checkbox"/> |
| (9) I stayed out at night without my parents<br>permission. .... | <input type="checkbox"/> |
| (10) I stole things from others. ....                            | <input type="checkbox"/> |
| (11) I set fires. ....   | <input type="checkbox"/> |
| (12) I broke windows or destroyed property. ....                 | <input type="checkbox"/> |
| (13) I ran away from home overnight<br>more than once. ....      | <input type="checkbox"/> |
| (14) I began skipping school, a lot,<br>before age 13. ....      | <input type="checkbox"/> |
| (15) I broke into someone's house,<br>building or car. ....      | <input type="checkbox"/> |

*Thank-you for your time*









**Comprehensive Holistic Health & House Calls**  
**Lynne Odell-Holzer, RN, Nurse Practitioner**  
Full spectrum of non-emergency medical health care  
services delivered by Nurse Practitioners  
for your primary care physical and mental health needs

### Consent for Release of Information

Person's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F

I hereby authorize and request: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release and/or receive confidential professional health related information with Comprehensive Holistic Health & House Calls (CHHHC), including medical reports, legal documents, psychological evaluations, school reports, psychiatric reports, etc. that may be needed for the optimum patient care. I understand that none of this information may be re-disclosed and that confidentiality of the patient and family will be maintained at all times. I also understand that I have the right to cancel permission to release information at any time by informing a professional staff member who will record the date, time, and reason of the cancellation.

Information requested: \_\_\_\_\_

This release of information also includes allowing the release of any alcohol and substance abuse information or treatment that you may have received. Please initial here that you have read and agree to release of any alcohol and substance abuse information: \_\_\_\_\_

This release of information is occurring with the knowledge and full consent of a competent adult person/parent/guardian. The only time this information may be released without the advance permission of a responsible adult is if it is subpoenaed by a court of law, if the patient is in danger of harming self or others, or there is a suggestion of abuse. Please initial here that you have read and understand this section: \_\_\_\_\_

Please initial here that you have read, understand, and agree with the HIPAA regulations regarding your rights and protections under the Notice of Privacy Practices: \_\_\_\_\_

Consent to release appropriate records to your insurance company occurred when you signed their waiver and again when you signed the insurance reassignment agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness

7751 Treadmill Circle  
Liverpool, NY 13090-2427  
**Voice/Fax: (315) 622-9241**  
e-mail: hhh@holzerent.com



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### Who We Are

Comprehensive Holistic Health & House Calls (CHHHC) is an organization of Nurse Practitioners who provide primary physical and health care services like those found in a traditional health care provider's office. This includes histories and physicals, follow up on many common physical and mental health conditions (from Attention Deficit Disorder to Zoster!), and treatment, including prescriptions. We have a number of physicians as our back-ups for any advice about care that might be beyond our scopes of practice.

We are a mobile primary care service established to provide routine medical care in your home by appointment. If you have a rapidly deteriorating health condition, still call 911.

### If You Already Have A Primary Health Care Provider

Many people prefer to keep their health care provider with whom they have had a long term relationship. If you wish CHHHC, NP's can provide the medical evaluation, treatment and coordinate these findings with your primary health care provider.

### Hours Of Operation

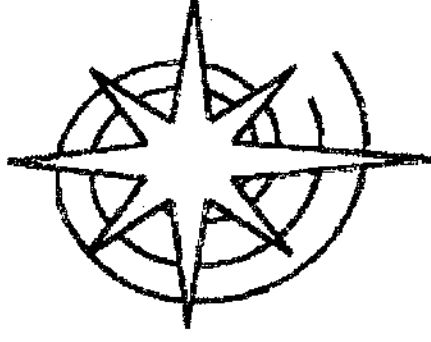
Hours for visits often vary according to CHHHC staff and your schedules.

Please feel free to call during standard business hours for more complete information.

We are a mobile primary care service established to provide routine medical care in your home. As always, 911 should be called in any non-routine health matter.

## COMPREHENSIVE HOLISTIC HEALTH & HOUSE CALLS

(Division of Holzer Enterprises)



Lynne Odell-Holzer, RN, NP  
Registered Nurse Practitioner  
in Family Medicine & Psychiatry

7751 TREADMILL CIRCLE  
LIVERPOOL, NY 13090-2427  
315-441-4411 Pager  
315-622-9241 Voice & Fax  
hhh@holzerent.com

## Our Philosophy

We believe that people are integrated, complex, beings who work hard to feel comfortable and to improve their lives. We believe that the mind and the body affect each other intimately. We believe that people are each complete individuals living and growing in the contexts of their environment and their genetic endowments. There are times when people cannot maintain their best health function. At those times, people may benefit from evaluation, management, treatment and education about their condition so that they can reach or return to independence and maximum function.

As a medically based health care service established to provide both mental and physical medical care, we use health principles of Western medicine to -

- 1) prevent dysfunction,
- 2) prevent complications from an unavoidable dysfunction, or
- 3) restore as much function as possible in chronic conditions.

Since an estimated 20% of the US population utilizes alternative, herbal, or non-Western health therapies, we have developed a familiarity with most of them. This way we can coordinate, teach, or refer those self-help strategies to safely combine them with traditional Western health care methods. We support and encourage self-help, self-determination, and return to independence of the individual. With that philosophy in mind, you can see why we expect that the person being 'treated' takes an active part to best meet this goal. We operate on a strengths-based philosophy. We strive to use what capacities the person already has to build, or re-build for maximum health and function.



## What We Provide

We provide care on a mobile basis to meet the person (patient) where the person best functions - the home. We are nurse practitioners trained to provide primary uncomplicated acute and chronic stable health care to people of any age.

We carry pagers for 24 hour coverage in the rare event that you have a health question that cannot wait for usual office hours.

## How To Pay

Since we are medically based and operate much like the "country doctor" of old, we are able to utilize most health insurances.

## To Reach Us

Leave a voice message and someone will usually return your call within 4 hours. You are also welcome to leave short messages at 622-9241.

**Comprehensive Holistic Health & House Calls      Patient Demographic Data**  
**7751 Treadmill Circle, Liverpool, NY 13090**  
**(315) 622-9241**

**Patient's Information:**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Gender: ☐ M ☐ F

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Other Phone (Specify): \_\_\_\_\_

Email: \_\_\_\_\_

SSN: \_\_\_\_\_

Marital Status: ☐ S ☐ M ☐ W ☐ D

Employment: ☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Student

Employer (if applicable): \_\_\_\_\_

Referred by: \_\_\_\_\_

Family doctor: \_\_\_\_\_

**Parent's Information (If applicable):**

Parents' Names: \_\_\_\_\_

Parents' address(es): ☐ Same as patient

Parents' Home Phone(s): \_\_\_\_\_

Parents' Work Phone(s): \_\_\_\_\_

Parents' Cell Phone(s): \_\_\_\_\_

Parents' Other Phone(s) (Specify): \_\_\_\_\_

Parent's Email(s): \_\_\_\_\_

**Guarantor's Information (Person financially responsible for the patient):**

Guarantor: ☐ Self ☐ Parent (If self or parent skip to the next section)

Guarantor's Name: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

Guarantor's address: ☐ Same as patient

Guarantor's Home Phone: \_\_\_\_\_

Guarantor's Work Phone: \_\_\_\_\_

Guarantor's Cell Phone: \_\_\_\_\_

Guarantor's Other Phone (Specify): \_\_\_\_\_

Guarantor's Email: \_\_\_\_\_

**Insurance Information:**

Primary

Company: \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber's Information:

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

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Secondary

Company: \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber's Information:

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

DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

**Other Information:**

Emergency Contact: \_\_\_\_\_

Other: \_\_\_\_\_

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

## HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information

New York State Department of Health

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ Both (non-HIV medical and HIV-related information)
- ☐ My non-HIV medical information \*\*

**Information in the box below must be completed.**

Name and address of facility/person disclosing HIV-related and/or medical information:	
<hr/> <hr/>	
Name of person whose information will be released: <hr/>	
Name and address of person signing this form (if other than above):	
<hr/> <hr/>	
Relationship to person whose information will be released: <hr/>	
<hr/>	
Describe information to be released: <hr/>	
Reason for release of information: <hr/>	
Time Period During Which Release of Information is Authorized From:	To: <hr/>
Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:	
<hr/> <hr/>	
Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):	
<hr/> <hr/>	

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Human Immunodeficiency Virus that causes AIDS

\*\* If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

HIPAA Compliant Authorization for Release of Medical Information  
and Confidential HIV\* Related Information

Complete information for each facility/person to be given general medical information and/or HIV-related information.  
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

Comprehensive Holistic Health & House Calls  
7751 Treadmill Circle  
Liverpool, N.Y. 13095-2427

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: \_\_\_\_\_

Print Name \_\_\_\_\_

Client/Patient Number \_\_\_\_\_

HIPAA Compliant Authorization for Release of Medical Information  
and Confidential HIV\* Related Information

Complete information for each facility/person to be given general medical information and/or HIV-related information.  
Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

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---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

Name and address of facility/person to be given general medical and/or HIV-related information:

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---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

Name and address of facility/person to be given general medical and/or HIV-related information:

---

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

---

---

If any/all of this page is completed, please sign below:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Client/Patient Number \_\_\_\_\_



# Comprehensive Home Holistic Health Care

LYNNE ODELL-HOLZER, NP, MSN

Registered Nurse Practitioner in Family Health & Psychiatry

Health & Illness  
Treatment & Education

Fax: (315) 622-9241  
hhh@holzerent.com

## CHILD/ADOLESCENT ASSESSMENT/EVALUATION FORM

\_\_\_\_\_INTAKE\_\_\_\_\_

\_\_\_\_\_ADDENDUM\_\_\_\_\_

At this first visit, please take the time to fill this form out to the best of your ability. The information that you and your child give me here will go a long way to help me get to know the background for your child. When filled out completely, this will help me to begin treatment recommendations and to support justifications to any insurers for appropriate payment on your child's behalf. Please feel confident that all this information is confidential. Also, please feel free to ask if any questions are confusing. Thank you, Lynne Odell-Holzer, RN, NP

### IDENTIFYING DATA:

DATE: \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_

Informants/Data Sources: \_\_\_\_\_

Age: \_\_\_\_\_ Ethnic background: ( )C ( )B ( )H ( )A ( )Other

Referral Source: ( )Family ( )School ( )CPS ( )Court ( )Probation  
( )Other \_\_\_\_\_

Agency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

REASON FOR CURRENT EVALUATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### CLIENT HISTORY:

#### Developmental History:

Pregnancy planned: ( )Yes ( )No Pregnancy wanted: ( )Yes ( )No

( )Premature ( )Postmature Length of pregnancy \_\_\_\_\_

Complications of Pregnancy: Excessive weight gain(how much?) \_\_\_\_\_

( )High blood pressure ( )Seizures ( )Bleeding (when?) \_\_\_\_\_

( )Threatened loss ( )Smoked (how much?)\_\_\_\_\_

On medications? (names)\_\_\_\_\_

( )Street drugs (names and amounts)\_\_\_\_\_

( )Alcohol (amount)\_\_\_\_\_

Complications of delivery: ( )Breech ( )Occiput posterior ( )Forceps ( )Anoxia

Length of prolonged labor\_\_\_\_\_ Birth weight: \_\_\_\_\_lbs \_\_\_\_\_oz.

Neonatal: How long nursed?\_\_\_\_\_ How long bottle fed?\_\_\_\_\_ Describe any feeding problems:\_\_\_\_\_

Describe any sleeping problems:\_\_\_\_\_

Describe any breathing problem:\_\_\_\_\_

Allergies\_\_\_\_\_ Rashes\_\_\_\_\_ Colic\_\_\_\_\_

Withdrew from holding?\_\_\_\_\_ Other\_\_\_\_\_

Walked\_\_\_\_\_months ( ) OK\_\_\_\_\_

Talked\_\_\_\_\_months ( ) OK\_\_\_\_\_

Toilet trained\_\_\_\_\_months ( )Easy ( )Difficult ( )Residual problem\_\_\_\_\_

Went to school: ( )Easily ( )With difficulty ( )With mother

Other separation problems: \_\_\_\_\_

Childhood behavior problems: ( )Firesetting ( )Cruelty to animals ( )Violence ( )Eating

( )Sleeping ( )Nightmares ( )Making Friends ( )Plays alone most of the time

( )Lying ( )Fighting ( )Stealing ( )Hurting others ( )Hurting self ( )Delinquency

( )Soiling ( )Wetting: Day/Night ( )Hyperactivity ( )Tired most of the time

( )Doesn't speak clearly ( )Always has aches & pains ( )Clumsy/accident prone

( )Fakes being sick ( )Problems learning in school ( )Won't obey school rules

( )Picks on others ( )Is picked on by others ( )Sex play with other children

( )Hangs with 'the wrong crowd' ( )Runs away from home ( )Damages property

( )Afraid of many things ( )Very shy ( )Poor loser ( )Demands too much attention

( )Talks back to grownups ( )Disobeys parents ( )Has 'chip on the shoulder'

( )Is sad or unhappy much of the time ( )Cries a lot ( )Temper tantrums

( )Mood changes quickly or without reason ( )Acts younger than real age



( ) Acts without thinking ( ) Wants things perfect ( ) Says or does strange or peculiar things  
( ) Is often confused or in a daze ( ) Daydreams a lot ( ) Seldom finishes things  
Other \_\_\_\_\_

Describe: \_\_\_\_\_

**Social/Family History:**

Place of birth \_\_\_\_\_ Raised by whom? \_\_\_\_\_

Minor's birth order \_\_\_\_\_ Brothers' ages \_\_\_\_\_ Sisters' ages \_\_\_\_\_

Since child was born, number of marriages for mom \_\_\_\_\_ number of marriages for dad \_\_\_\_\_

Parents are currently: Married Living together Separated Divorced Other: \_\_\_\_\_

No longer connected \_\_\_\_\_ Amicable or hostile \_\_\_\_\_

Type of Employment: Father \_\_\_\_\_ Mother \_\_\_\_\_

Present living situation: ( ) Apartment ( ) Trailer ( ) Home ( ) Other \_\_\_\_\_

With whom: \_\_\_\_\_

Child's age at parents' divorce \_\_\_\_\_ Child's age at adoption \_\_\_\_\_

Has child ever been placed out of the home? ( ) No ( ) Yes

Where? \_\_\_\_\_

When? \_\_\_\_\_

Reason? \_\_\_\_\_

Child's adjustment in the family ( ) Good ( ) Tense ( ) Fights with brothers

( ) Fights with sisters ( ) Resists mother ( ) Resists father

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

Types of discipline used, when & by whom \_\_\_\_\_

Religious affiliation(s) \_\_\_\_\_

Other significant information (i.e. alliances, coalitions, child's reaction to family members, traumatic events in family's life, or illnesses in the family, family conflicts, usage of drugs and/or alcohol in the family.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Peer relationships: ( )Leader ( )Accepted ( )Rejected ( )Follower ( )Isolated ( ) Some  
( ) Reclusive ( )Many/long time ( )Few/temporary ( )No friend

Who would you go to if hurt, sad, etc.? \_\_\_\_\_

Support system: ( )Mother ( )Father ( )Friend ( )Teacher ( )Professional  
( )Relative

Hobbies/favorite activities \_\_\_\_\_

### **School History:**

Present/last school \_\_\_\_\_ Year in school \_\_\_\_\_

Typical grades \_\_\_\_\_ Classes: Regular Special (specify) \_\_\_\_\_

Repeated grades \_\_\_\_\_ Number of different schools \_\_\_\_\_ Attendance record \_\_\_\_\_

What do you like best in school: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Legal and Juvenile Hall History:** None or if on probation, list charges: \_\_\_\_\_

### **Mental Health History:**

Family history of mental illness or emotional/behavioral problems in siblings, parents, or  
grandparents (include alcohol & drug use history either past or present) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Age when patient's emotional problems began \_\_\_\_\_ History of problems \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Psychiatric hospitalizations: (When and where?) \_\_\_\_\_

\_\_\_\_\_  
If outpatient therapy, therapist, length of treatment, & when \_\_\_\_\_

Previous medications: \_\_\_\_\_

Total length of time on medications \_\_\_\_\_

Suicide history: None or circumstances, methods tried & when \_\_\_\_\_

Homicide history: None or circumstances, methods tried, who & when \_\_\_\_\_

Current medications for emotional problems \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Other: \_\_\_\_\_

**Physical Health History:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Unusual movements/tics \_\_\_\_\_

Any handicaps such as hearing or vision problems \_\_\_\_\_

Any recurrent health problems: \_\_\_\_\_

Any medications for physical problems \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Previous health: No problems or broken bones, injuries, accidents, operations: \_\_\_\_\_

Hospitalizations (time + reason) \_\_\_\_\_

Allergies to foods/medications/other \_\_\_\_\_

Any herbals or supplements \_\_\_\_\_

Any head injuries, seizures, periods of unconsciousness or other neurological symptoms or problems \_\_\_\_\_

Family Health history in siblings, parents, & grandparents \_\_\_\_\_

Sleep: Bedtime \_\_\_\_\_ Awake time \_\_\_\_\_ Trouble initiating, staying asleep or arising? \_\_\_\_\_

Any sleep disturbances \_\_\_\_\_

Appetite, average number of meals & quality of diet \_\_\_\_\_

Average amount of sodas, chocolate or coffee a day \_\_\_\_\_

Regular exercise habits \_\_\_\_\_

Sexual orientation: Too young    Heterosexual    Homosexual    Bisexual    Sexually Active?

Tobacco, alcohol, or recreational drug habits \_\_\_\_\_

Begun puberty/ in puberty/ finished puberty? \_\_\_\_\_

Any menstrual or hormonal irregularities? \_\_\_\_\_

Any other helpful information \_\_\_\_\_

**OPTIONAL QUESTIONS:**

What animals do you like best and least? (why) \_\_\_\_\_

What would you do if you were in a theater and there was a fire? \_\_\_\_\_

What would you do if you found an addressed letter with a stamp? \_\_\_\_\_

What would you wish for if you had three magic wishes? \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What would you like to be when you grow up? \_\_\_\_\_

Again, thank you for your help. You are halfway through the initial intake process ---time to congratulate yourselves! Please be a little more patient while I review this information and prepare for further questions to do the best I can for you.

Lynne

- 

www.holzerent.com

7751 Treadmill Circle, Liverpool, NY 13090-2427  
hhh@holzerent.com Ofc & Fax: (315) 622-9241

hnh@holzerent.com Ofc & Fax: (315) 622-9241

John A. Schinka, Ph.D.

Completed by \_\_\_\_\_

This checklist asks questions about the child's developmental history and current life. Begin by entering the child's name, age, and sex at the top of this page. Then enter the date, your name, and your relationship to the child. Turn to the inside of this booklet and answer the questions. All of the questions are numbered in order. For each question, make a mark (X) next to the answer that describes the child's history or current life. Many questions have a space labeled *Other* for writing in an answer if the correct answer is not provided. Questions followed by the symbol (✓✓✓) should be marked with all the answers that apply. For questions that do not apply, mark the answer *Does not apply*.

53. Which of the following has the child attended (✓✓✓)?

X C. Preschool

X D. Kindergarten

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## I. PRESENTING INFORMATION

1. What is the child's race?
- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> A. White    | <input type="checkbox"/> E. Asian           |
| <input type="checkbox"/> B. Black    | <input type="checkbox"/> F. Native American |
| <input type="checkbox"/> C. Oriental | <input type="checkbox"/> G. Other _____     |
| <input type="checkbox"/> D. Hispanic |   |
2. What is your relationship to the child?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Natural mother  | <input type="checkbox"/> I. Grandmother       |
| <input type="checkbox"/> B. Natural father  | <input type="checkbox"/> J. Grandfather       |
| <input type="checkbox"/> C. Stepmother      | <input type="checkbox"/> K. Older sister      |
| <input type="checkbox"/> D. Stepfather      | <input type="checkbox"/> L. Older brother     |
| <input type="checkbox"/> E. Adoptive mother | <input type="checkbox"/> M. Social worker     |
| <input type="checkbox"/> F. Adoptive father | <input type="checkbox"/> N. Agency caseworker |
| <input type="checkbox"/> G. Foster mother   | <input type="checkbox"/> O. Other _____       |
| <input type="checkbox"/> H. Foster father   |   |
3. Who is responsible for the child's care at this time?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Natural parents               | <input type="checkbox"/> G. Grandparents   |
| <input type="checkbox"/> B. Natural mother                | <input type="checkbox"/> H. Grandmother    |
| <input type="checkbox"/> C. Natural father                | <input type="checkbox"/> I. Grandfather    |
| <input type="checkbox"/> D. Natural mother and stepfather | <input type="checkbox"/> J. Foster parents |
| <input type="checkbox"/> E. Natural father and stepmother | <input type="checkbox"/> K. Orphanage      |
| <input type="checkbox"/> F. Adoptive parents              | <input type="checkbox"/> L. Agency         |
|   | <input type="checkbox"/> M. Other _____    |
4. Who referred the child here, or recommended that the child come here?
- |   |   |
|---|---|
| <input type="checkbox"/> A. No one, decided yourself to bring the child | <input type="checkbox"/> F. A community agency                                |
| <input type="checkbox"/> B. Friend of the family                        | <input type="checkbox"/> G. A priest, pastor, or other religious staff person |
| <input type="checkbox"/> C. Pediatrician                                | <input type="checkbox"/> H. The police  |
| <input type="checkbox"/> D. Family doctor                               | <input type="checkbox"/> I. A judge   |
| <input type="checkbox"/> E. School                                      | <input type="checkbox"/> J. Other _____                                       |
5. What is the main problem that led to the child being brought here?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Child has no problem           | <input type="checkbox"/> K. Refusal to go to school   |
| <input type="checkbox"/> B. Depression                     | <input type="checkbox"/> L. Behavior problems at home |
| <input type="checkbox"/> C. Anxiety                        | <input type="checkbox"/> M. Health problems           |
| <input type="checkbox"/> D. Suicidal thoughts              | <input type="checkbox"/> N. Physical abuse            |
| <input type="checkbox"/> E. Suicidal actions               | <input type="checkbox"/> O. Sexual abuse              |
| <input type="checkbox"/> F. Problems with thinking clearly | <input type="checkbox"/> P. Neglect by parents        |
| <input type="checkbox"/> G. Arguments with parents         | <input type="checkbox"/> Q. Bed-wetting               |
| <input type="checkbox"/> H. Adjustment to parents' divorce | <input type="checkbox"/> R. Stealing                  |
| <input type="checkbox"/> I. Academic problems              | <input type="checkbox"/> S. Fears                     |
| <input type="checkbox"/> J. Behavior problems in school    | <input type="checkbox"/> T. Other _____               |
6. How severe is this problem?
- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> C. Moderate |
| <input type="checkbox"/> B. Mild           | <input type="checkbox"/> D. Severe   |

7. How long has the child had this problem?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply              | <input type="checkbox"/> E. For the past year          |
| <input type="checkbox"/> B. For the past several days   | <input type="checkbox"/> F. For the past two years     |
| <input type="checkbox"/> C. For the past several weeks  | <input type="checkbox"/> G. For the past several years |
| <input type="checkbox"/> D. For the past several months |  |
8. Which of the following has this problem affected (✓✓✓)?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply                                | <input type="checkbox"/> F. The child's physical health  |
| <input type="checkbox"/> B. None  | <input type="checkbox"/> G. The child's emotional health |
| <input type="checkbox"/> C. The child's academic performance              | <input type="checkbox"/> H. The child's behavior         |
| <input type="checkbox"/> D. The child's relationships with peers          | <input type="checkbox"/> I. Other _____                  |
| <input type="checkbox"/> E. The child's relationships with family members |  |
9. Has the child been treated for this problem before?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                     | <input type="checkbox"/> E. Yes, but without success |
| <input type="checkbox"/> B. No                                 |  |
| <input type="checkbox"/> C. Yes, with success                  |  |
| <input type="checkbox"/> D. Yes, but with only partial success |  |
10. What other problems is the child having (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. None                           | <input type="checkbox"/> K. Refusal to go to school   |
| <input type="checkbox"/> B. Depression                     | <input type="checkbox"/> L. Behavior problems at home |
| <input type="checkbox"/> C. Anxiety                        | <input type="checkbox"/> M. Health problems           |
| <input type="checkbox"/> D. Suicidal thoughts              | <input type="checkbox"/> N. Physical abuse            |
| <input type="checkbox"/> E. Suicidal actions               | <input type="checkbox"/> O. Sexual abuse              |
| <input type="checkbox"/> F. Problems with thinking clearly | <input type="checkbox"/> P. Neglect by parents        |
| <input type="checkbox"/> G. Arguments with parents         | <input type="checkbox"/> Q. Bed-wetting               |
| <input type="checkbox"/> H. Adjustment to parents' divorce | <input type="checkbox"/> R. Stealing                  |
| <input type="checkbox"/> I. Academic problems              | <input type="checkbox"/> S. Fears                     |
| <input type="checkbox"/> J. Behavior problems in school    | <input type="checkbox"/> T. Other _____               |

## II. PERSONAL INFORMATION AND FAMILY BACKGROUND

11. What is the child's status in school?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Has not yet started school           | <input type="checkbox"/> F. Suspended from school |
| <input type="checkbox"/> B. Full-time, regular classes           | <input type="checkbox"/> G. Expelled from school  |
| <input type="checkbox"/> C. Part-time, regular classes           | <input type="checkbox"/> H. Being tutored at home |
| <input type="checkbox"/> D. Full-time, special education classes | <input type="checkbox"/> I. On summer vacation    |
| <input type="checkbox"/> E. Part-time, special education classes | <input type="checkbox"/> J. Other _____           |

12. What grade is the child in now (or when school starts again in the fall)?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> A. Not in school; will not be in school | <input type="checkbox"/> F. Third   |
| <input type="checkbox"/> B. Preschool                            | <input type="checkbox"/> G. Fourth  |
| <input type="checkbox"/> C. Kindergarten                         | <input type="checkbox"/> H. Fifth   |
| <input type="checkbox"/> D. First                                | <input type="checkbox"/> I. Sixth   |
| <input type="checkbox"/> E. Second                               | <input type="checkbox"/> J. Seventh |
|  | <input type="checkbox"/> K. Eighth  |

13. What type of school does the child attend?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Not attending school       | <input type="checkbox"/> F. Orphanage school |
| <input type="checkbox"/> B. Public school              | <input type="checkbox"/> G. Military academy |
| <input type="checkbox"/> C. Private school             | <input type="checkbox"/> H. Boarding school  |
| <input type="checkbox"/> D. Parochial school           | <input type="checkbox"/> I. Other _____      |
| <input type="checkbox"/> E. School for the handicapped |  |

14. Who does the child live with?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Natural parents                                      | <input type="checkbox"/> G. Relatives                         |
| <input type="checkbox"/> B. Natural mother                                       | <input type="checkbox"/> H. Friends                           |
| <input type="checkbox"/> C. Natural father                                       | <input type="checkbox"/> I. Adoptive parents                  |
| <input type="checkbox"/> D. Natural mother and stepfather                        | <input type="checkbox"/> J. Foster parents                    |
| <input type="checkbox"/> E. Natural father and stepmother                        | <input type="checkbox"/> K. Lives in an orphanage             |
| <input type="checkbox"/> F. Shared living arrangement with both divorced parents | <input type="checkbox"/> L. Lives in an agency                |
|  | <input type="checkbox"/> M. Lives in a charitable institution |
|  | <input type="checkbox"/> N. Other _____                       |

15. Where does the child live?

- |   |   |
|---|---|
| <input type="checkbox"/> A. House       | <input type="checkbox"/> E. Boarding school |
| <input type="checkbox"/> B. Apartment   | <input type="checkbox"/> F. Agency housing  |
| <input type="checkbox"/> C. Trailer     | <input type="checkbox"/> G. Institution     |
| <input type="checkbox"/> D. Condominium | <input type="checkbox"/> H. Other _____     |

16. How many children are in the child's family?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply        | <input type="checkbox"/> H. 7 including the child            |
| <input type="checkbox"/> B. Only child            | <input type="checkbox"/> I. 8 including the child            |
| <input type="checkbox"/> C. 2 including the child | <input type="checkbox"/> J. 9 including the child            |
| <input type="checkbox"/> D. 3 including the child | <input type="checkbox"/> K. 10 including the child           |
| <input type="checkbox"/> E. 4 including the child | <input type="checkbox"/> L. More than 10 including the child |
| <input type="checkbox"/> F. 5 including the child |  |
| <input type="checkbox"/> G. 6 including the child |  |

17. Of the other children in the family, how many are stepbrothers and stepsisters?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> G. 5           |
| <input type="checkbox"/> B. None           | <input type="checkbox"/> H. 6           |
| <input type="checkbox"/> C. 1              | <input type="checkbox"/> I. 7           |
| <input type="checkbox"/> D. 2              | <input type="checkbox"/> J. 8           |
| <input type="checkbox"/> E. 3              | <input type="checkbox"/> K. More than 8 |
| <input type="checkbox"/> F. 4              |   |

18. What is the child's position in the family?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply, only child | <input type="checkbox"/> C. A middle child   |
| <input type="checkbox"/> B. The youngest child         | <input type="checkbox"/> D. The oldest child |
|  | <input type="checkbox"/> E. Other _____      |

19. How much education has the child's current male caretaker (for example, father, stepfather, foster father) completed?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> G. Some college     |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> H. College graduate |
| <input type="checkbox"/> C. Less than eighth grade | <input type="checkbox"/> I. Master's degree  |
| <input type="checkbox"/> D. Eighth grade           | <input type="checkbox"/> J. Medical degree   |
| <input type="checkbox"/> E. Some high school       | <input type="checkbox"/> K. Law degree       |
| <input type="checkbox"/> F. High school graduate   | <input type="checkbox"/> L. Doctoral degree  |
|  | <input type="checkbox"/> M. Other _____      |

20. What is the main type of work the child's current male caretaker (for example, father, stepfather, foster father) does?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply  | <input type="checkbox"/> K. Business manager  |
| <input type="checkbox"/> B. Do not know   | <input type="checkbox"/> L. Health professional (for example: doctor, surgeon)                      |
| <input type="checkbox"/> C. Has primarily been unemployed                           | <input type="checkbox"/> M. Social services professional (for example: psychologist, social worker) |
| <input type="checkbox"/> D. Works in many different occupations                     | <input type="checkbox"/> N. Business executive  |
| <input type="checkbox"/> E. Unskilled worker (for example: factory worker, laborer) | <input type="checkbox"/> O. Not employed outside the home   |
| <input type="checkbox"/> F. Skilled worker (for example: welder, carpenter)         | <input type="checkbox"/> P. Military service  |
| <input type="checkbox"/> G. Clerical worker   | <input type="checkbox"/> Q. Other _____   |
| <input type="checkbox"/> H. Salesperson   |   |
| <input type="checkbox"/> I. Small business owner                                    |   |
| <input type="checkbox"/> J. Technical specialist (for example: computer programmer) |   |

21. Which of the following is true about the child's current male caretaker (for example, father, stepfather, foster father)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply              | <input type="checkbox"/> E. This is his second marriage             |
| <input type="checkbox"/> B. Do not know                 | <input type="checkbox"/> F. He has been married more than two times |
| <input type="checkbox"/> C. He is not presently married |   |
| <input type="checkbox"/> D. This is his first marriage  |   |

22. How much education has the child's current female caretaker (for example, mother, stepmother, foster mother) completed?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> G. Some college     |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> H. College graduate |
| <input type="checkbox"/> C. Less than eighth grade | <input type="checkbox"/> I. Master's degree  |
| <input type="checkbox"/> D. Eighth grade           | <input type="checkbox"/> J. Medical degree   |
| <input type="checkbox"/> E. Some high school       | <input type="checkbox"/> K. Law degree       |
| <input type="checkbox"/> F. High school graduate   | <input type="checkbox"/> L. Doctoral degree  |
|  | <input type="checkbox"/> M. Other _____      |

23. What is the main type of work the child's current female caretaker (for example, mother, stepmother, foster mother) does?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply  | <input type="checkbox"/> K. Business manager  |
| <input type="checkbox"/> B. Do not know   | <input type="checkbox"/> L. Health professional (for example: doctor, surgeon)                      |
| <input type="checkbox"/> C. Has primarily been unemployed                           | <input type="checkbox"/> M. Social services professional (for example: psychologist, social worker) |
| <input type="checkbox"/> D. Works in many different occupations                     | <input type="checkbox"/> N. Business executive  |
| <input type="checkbox"/> E. Unskilled worker (for example: factory worker, laborer) | <input type="checkbox"/> O. Not employed outside the home   |
| <input type="checkbox"/> F. Skilled worker (for example: welder, carpenter)         | <input type="checkbox"/> P. Military service  |
| <input type="checkbox"/> G. Clerical worker   | <input type="checkbox"/> Q. Other _____   |
| <input type="checkbox"/> H. Salesperson   |   |
| <input type="checkbox"/> I. Small business owner                                    |   |
| <input type="checkbox"/> J. Technical specialist (for example: computer programmer) |   |
24. Which of the following is true about the child's current female caretaker (for example, mother, stepmother, foster mother)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply               | <input type="checkbox"/> E. This is her second marriage              |
| <input type="checkbox"/> B. Do not know                  | <input type="checkbox"/> F. She has been married more than two times |
| <input type="checkbox"/> C. She is not presently married |  |
| <input type="checkbox"/> D. This is her first marriage   |  |
25. What is the main source of income for the child's household family?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply     | <input type="checkbox"/> F. Welfare                |
| <input type="checkbox"/> B. Do not know        | <input type="checkbox"/> G. Alimony                |
| <input type="checkbox"/> C. Father's job       | <input type="checkbox"/> H. Child support payments |
| <input type="checkbox"/> D. Mother's job       | <input type="checkbox"/> I. Other _____            |
| <input type="checkbox"/> E. Both parents' jobs |  |
26. What is the economic status of the child's household family?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> D. Lower class  |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> E. Middle class |
| <input type="checkbox"/> C. Poverty level  | <input type="checkbox"/> F. Upper class  |

### III. EARLY DEVELOPMENTAL HISTORY

27. How old was the child's natural father at the time of the child's birth?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> D. 30-39       |
| <input type="checkbox"/> B. 15-19       | <input type="checkbox"/> E. 40-49       |
| <input type="checkbox"/> C. 20-29       | <input type="checkbox"/> F. 50 or older |
28. How old was the child's natural mother at the time of the child's birth?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> D. 30-39       |
| <input type="checkbox"/> B. 15-19       | <input type="checkbox"/> E. 40-49       |
| <input type="checkbox"/> C. 20-29       | <input type="checkbox"/> F. 50 or older |

29. How many times was the child's mother pregnant prior to the child's birth?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> E. 3           |
| <input type="checkbox"/> B. None        | <input type="checkbox"/> F. 4           |
| <input type="checkbox"/> C. 1           | <input type="checkbox"/> G. 5           |
| <input type="checkbox"/> D. 2           | <input type="checkbox"/> H. More than 5 |
30. Did any of the mother's previous pregnancies end by miscarriage?
- |  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> C. Yes |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> D. No  |
31. Was the pregnancy planned?
- |   |                                |
|---|--------------------------------|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> C. No |
| <input type="checkbox"/> B. Yes         |                                |
32. What was the mother's attitude while pregnant with the child (✓✓✓)?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> F. Depressed   |
| <input type="checkbox"/> B. Accepting   | <input type="checkbox"/> G. Worried     |
| <input type="checkbox"/> C. Ambivalent  | <input type="checkbox"/> H. Fearful     |
| <input type="checkbox"/> D. Happy       | <input type="checkbox"/> I. Moody       |
| <input type="checkbox"/> E. Angry       | <input type="checkbox"/> J. Other _____ |
33. Did the mother receive medical care while pregnant with the child?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> C. Yes, regularly    |
| <input type="checkbox"/> B. No          | <input type="checkbox"/> D. Yes, a few visits |
34. What was the mother's condition while pregnant with the child (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Do not know                | <input type="checkbox"/> M. Smoked less than one pack of cigarettes per day |
| <input type="checkbox"/> B. Normal, no health problems | <input type="checkbox"/> N. Smoked more than one pack of cigarettes per day |
| <input type="checkbox"/> C. Threatened miscarriage     | <input type="checkbox"/> O. Did not use illegal drugs                       |
| <input type="checkbox"/> D. Bleeding                   | <input type="checkbox"/> P. Used illegal drugs                              |
| <input type="checkbox"/> E. High blood pressure        | <input type="checkbox"/> Q. Did not take prescription drugs                 |
| <input type="checkbox"/> F. Toxemia                    | <input type="checkbox"/> R. Took prescription drugs                         |
| <input type="checkbox"/> G. Diabetes                   | <input type="checkbox"/> S. Other _____                                     |
| <input type="checkbox"/> H. Frequent nausea            |   |
| <input type="checkbox"/> I. Did not use alcohol        |   |
| <input type="checkbox"/> J. Drank alcohol infrequently |   |
| <input type="checkbox"/> K. Drank alcohol frequently   |   |
| <input type="checkbox"/> L. Did not smoke cigarettes   |   |
35. What were the conditions of the child's birth (✓✓✓)?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know                 | <input type="checkbox"/> F. Complications with delivery |
| <input type="checkbox"/> B. Normal, no unusual problems | <input type="checkbox"/> G. Breech birth                |
| <input type="checkbox"/> C. Premature birth             | <input type="checkbox"/> H. Caesarean delivery          |
| <input type="checkbox"/> D. Long labor                  | <input type="checkbox"/> I. Rh factor problems          |
| <input type="checkbox"/> E. Mother ill at time of birth | <input type="checkbox"/> J. Other _____                 |



36. What was the child's physical condition immediately after birth (✓✓✓)?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Do not know                 | <input type="checkbox"/> I. Infection                |
| <input type="checkbox"/> B. Normal, no unusual problems | <input type="checkbox"/> J. Jaundice                 |
| <input type="checkbox"/> C. Injured at birth            | <input type="checkbox"/> K. Fever                    |
| <input type="checkbox"/> D. Difficulty breathing        | <input type="checkbox"/> L. Had seizures             |
| <input type="checkbox"/> E. Problems with heart         | <input type="checkbox"/> M. Had blood transfusion    |
| <input type="checkbox"/> F. Problems with bones         | <input type="checkbox"/> N. Placed in intensive care |
| <input type="checkbox"/> G. Problems with digestion     | <input type="checkbox"/> O. Placed in incubator      |
| <input type="checkbox"/> H. Low birth weight            | <input type="checkbox"/> P. Other _____              |
37. Approximately how much did the child weigh when born?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> G. 6 pounds       |
| <input type="checkbox"/> B. 1 pound     | <input type="checkbox"/> H. 7 pounds       |
| <input type="checkbox"/> C. 2 pounds    | <input type="checkbox"/> I. 8 pounds       |
| <input type="checkbox"/> D. 3 pounds    | <input type="checkbox"/> J. 9 pounds       |
| <input type="checkbox"/> E. 4 pounds    | <input type="checkbox"/> K. 10 pounds      |
| <input type="checkbox"/> F. 5 pounds    | <input type="checkbox"/> L. Over 10 pounds |
38. How many days did the child spend in the hospital after birth?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Do not know      | <input type="checkbox"/> D. More than 10 days |
| <input type="checkbox"/> B. 5 days or less   | <input type="checkbox"/> E. More than 20 days |
| <input type="checkbox"/> C. More than 5 days | <input type="checkbox"/> F. More than 30 days |
39. Who was the child's primary caretaker before age 2?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Natural parents               | <input type="checkbox"/> G. Grandparents   |
| <input type="checkbox"/> B. Natural mother                | <input type="checkbox"/> H. Grandmother    |
| <input type="checkbox"/> C. Natural father                | <input type="checkbox"/> I. Grandfather    |
| <input type="checkbox"/> D. Natural mother and stepfather | <input type="checkbox"/> J. Foster parents |
| <input type="checkbox"/> E. Natural father and stepmother | <input type="checkbox"/> K. Orphanage      |
| <input type="checkbox"/> F. Adoptive parents              | <input type="checkbox"/> L. Agency         |
|   | <input type="checkbox"/> M. Other _____    |
40. Describe the child's temperament before age 2 (✓✓✓).
- |  |  |
|--|--|
| <input type="checkbox"/> A. Do not know  | <input type="checkbox"/> L. Difficult      |
| <input type="checkbox"/> B. Calm         | <input type="checkbox"/> M. Irritable      |
| <input type="checkbox"/> C. Active       | <input type="checkbox"/> N. Hypersensitive |
| <input type="checkbox"/> D. Sociable     | <input type="checkbox"/> O. Angry          |
| <input type="checkbox"/> E. Withdrawn    | <input type="checkbox"/> P. Regular        |
| <input type="checkbox"/> F. Happy        | <input type="checkbox"/> Q. Irregular      |
| <input type="checkbox"/> G. Unhappy      | <input type="checkbox"/> R. Fearful        |
| <input type="checkbox"/> H. Alert        | <input type="checkbox"/> S. Cranky         |
| <input type="checkbox"/> I. Sleepy       | <input type="checkbox"/> T. Curious        |
| <input type="checkbox"/> J. Affectionate | <input type="checkbox"/> U. Playful        |
| <input type="checkbox"/> K. Crying       | <input type="checkbox"/> V. Other _____    |
41. How was the child fed before age 2?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> C. Breast            |
| <input type="checkbox"/> B. Bottle      | <input type="checkbox"/> D. Bottle and breast |
42. From birth to age 2, when did the child develop physical skills such as sitting, crawling, and reaching up?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Do not know                             | <input type="checkbox"/> D. Later than most children |
| <input type="checkbox"/> B. Earlier than most children              | <input type="checkbox"/> E. Other _____              |
| <input type="checkbox"/> C. At about the same time as most children |  |
43. When did the child learn to walk?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know   | <input type="checkbox"/> D. 1½ to 2 years |
| <input type="checkbox"/> B. Before 1 year | <input type="checkbox"/> E. After 2 years |
| <input type="checkbox"/> C. 1 to 1½ years | <input type="checkbox"/> F. Other _____   |
44. When did the child learn to talk?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know   | <input type="checkbox"/> D. 1½ to 2 years |
| <input type="checkbox"/> B. Before 1 year | <input type="checkbox"/> E. After 2 years |
| <input type="checkbox"/> C. 1 to 1½ years | <input type="checkbox"/> F. Other _____   |
45. When did toilet training begin?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know   | <input type="checkbox"/> G. 3 years       |
| <input type="checkbox"/> B. Before 1 year | <input type="checkbox"/> H. 3½ years      |
| <input type="checkbox"/> C. 1 year        | <input type="checkbox"/> I. 4 years       |
| <input type="checkbox"/> D. 1½ years      | <input type="checkbox"/> J. After 4 years |
| <input type="checkbox"/> E. 2 years       | <input type="checkbox"/> K. Other _____   |
| <input type="checkbox"/> F. 2½ years      |   |
46. Were there problems in toilet training?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know     | <input type="checkbox"/> D. Moderate problems |
| <input type="checkbox"/> B. No              | <input type="checkbox"/> E. Mild problems     |
| <input type="checkbox"/> C. Severe problems |   |
47. Who was the child's primary caretaker from ages 2-5?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Natural parents               | <input type="checkbox"/> G. Grandparents   |
| <input type="checkbox"/> B. Natural mother                | <input type="checkbox"/> H. Grandmother    |
| <input type="checkbox"/> C. Natural father                | <input type="checkbox"/> I. Grandfather    |
| <input type="checkbox"/> D. Natural mother and stepfather | <input type="checkbox"/> J. Foster parents |
| <input type="checkbox"/> E. Natural father and stepmother | <input type="checkbox"/> K. Orphanage      |
| <input type="checkbox"/> F. Adoptive parents              | <input type="checkbox"/> L. Agency         |
|   | <input type="checkbox"/> M. Other _____    |
48. Describe the child's motor development (running, jumping, throwing, catching, etc.) from ages 2-5.
- |  |  |
|--|--|
| <input type="checkbox"/> A. Do not know                              | <input type="checkbox"/> D. Slow in comparison to other children |
| <input type="checkbox"/> B. Advanced in comparison to other children | <input type="checkbox"/> E. Other _____                          |
| <input type="checkbox"/> C. Average in comparison to other children  |  |
49. Describe the child's language development (talking in sentences, vocabulary, etc.) from ages 2-5.
- |  |  |
|--|--|
| <input type="checkbox"/> A. Do not know                              | <input type="checkbox"/> D. Slow in comparison to other children |
| <input type="checkbox"/> B. Advanced in comparison to other children | <input type="checkbox"/> E. Other _____                          |
| <input type="checkbox"/> C. Average in comparison to other children  |  |
50. Describe the child's social development (development of friendships, relationships with peers, relationships with adults, etc.) from ages 2-5.
- |  |  |
|--|--|
| <input type="checkbox"/> A. Do not know                              | <input type="checkbox"/> D. Slow in comparison to other children |
| <input type="checkbox"/> B. Advanced in comparison to other children | <input type="checkbox"/> E. Other _____                          |
| <input type="checkbox"/> C. Average in comparison to other children  |  |

51. Describe the child's mental development (counting, knowledge of alphabet, doing puzzles, understanding concepts, etc.) from ages 2-5.
- ☐ A. Do not know ☐ D. Slow in comparison to other children
- ☐ B. Advanced in comparison to other children ☐ E. Other \_\_\_\_\_
- ☐ C. Average in comparison to other children
52. Describe the child's temperament from ages 2-5 (✓✓✓).
- ☐ A. Do not know ☐ L. Difficult
- ☐ B. Calm ☐ M. Irritable
- ☐ C. Active ☐ N. Hypersensitive
- ☐ D. Sociable ☐ O. Angry
- ☐ E. Withdrawn ☐ P. Regular
- ☐ F. Happy ☐ Q. Irregular
- ☐ G. Unhappy ☐ R. Fearful
- ☐ H. Alert ☐ S. Cranky
- ☐ I. Sleepy ☐ T. Curious
- ☐ J. Affectionate ☐ U. Playful
- ☐ K. Crying ☐ V. Other \_\_\_\_\_

#### IV. EDUCATIONAL HISTORY

53. Which of the following has the child attended (✓✓✓)?
- ☐ A. None ☐ C. Preschool
- ☐ B. Infant day care ☐ D. Kindergarten
54. What types of schools has the child attended (✓✓✓)?
- ☐ A. None ☐ F. Orphanage school
- ☐ B. Public school ☐ G. Military academy
- ☐ C. Private school ☐ H. Boarding school
- ☐ D. Parochial school ☐ I. Other \_\_\_\_\_
- ☐ E. School for the handicapped
55. At what age did the child start kindergarten?
- ☐ A. Has not attended kindergarten ☐ D. 6
- ☐ B. 4 ☐ E. 7
- ☐ C. 5 ☐ F. Older than 7 years old
56. Did the child have any problems when starting kindergarten (✓✓✓)?
- ☐ A. Does not apply ☐ E. Had to be punished to go to school
- ☐ B. No ☐ F. Other \_\_\_\_\_
- ☐ C. Was afraid of school ☐ D. Complained of being ill to avoid going to school
57. Which of the following describes the child's experience in kindergarten?
- ☐ A. Does not apply ☐ D. Disliked school
- ☐ B. Enjoyed school
- ☐ C. Felt neutral about school

58. Which of the following describes the child's experience in kindergarten?
- ☐ A. Does not apply ☐ D. Usually got along poorly with the teacher
- ☐ B. Got along well with the teacher
- ☐ C. Got along fairly well with the teacher
59. Which of the following describe the child's experiences in kindergarten (✓✓✓)?
- ☐ A. Does not apply ☐ E. Had to be disciplined in school frequently
- ☐ B. None ☐ F. Other \_\_\_\_\_
- ☐ C. Did not get along with other children
- ☐ D. Frequently absent for health reasons
60. Which of the following describe the child's behavior in kindergarten (✓✓✓).
- ☐ A. Does not apply ☐ F. Disobedient
- ☐ B. None ☐ G. Distractible
- ☐ C. Fearful ☐ H. Active
- ☐ D. Withdrawn ☐ I. Other \_\_\_\_\_
- ☐ E. Aggressive
61. Describe the child's academic performance in kindergarten.
- ☐ A. Does not apply ☐ D. Slow
- ☐ B. Advanced ☐ E. Other \_\_\_\_\_
- ☐ C. Average
62. Describe the child's experiences in kindergarten (✓✓✓).
- ☐ A. Does not apply ☐ F. Evaluated by psychologist
- ☐ B. None ☐ G. Recommended for retention
- ☐ C. Suspended ☐ H. Retained
- ☐ D. Placed in full-time special education class ☐ I. Other \_\_\_\_\_
- ☐ E. Placed in part-time special education class
63. At what age did the child start the first grade?
- ☐ A. Has not attended first grade ☐ D. 7
- ☐ B. 5 ☐ E. 8
- ☐ C. 6 ☐ F. More than 8 years old
64. Did the child have any problems when starting the first grade (✓✓✓)?
- ☐ A. Does not apply ☐ E. Had to be punished to go to school
- ☐ B. No ☐ F. Other \_\_\_\_\_
- ☐ C. Was afraid of school ☐ D. Complained of being ill to avoid going to school
65. Which of the following describes the child's experience in the first grade?
- ☐ A. Does not apply ☐ D. Disliked school
- ☐ B. Enjoyed school
- ☐ C. Felt neutral about school

66. Which of the following describes the child's experience in the first grade?

- ☐ A. Does not apply  
☐ B. Got along well with the teacher  
☐ C. Got along fairly well with the teacher  
☐ D. Usually got along poorly with the teacher

67. Which of the following describe the child's experiences in the first grade?

- ☐ A. Does not apply  
☐ B. None  
☐ C. Did not get along with other children  
☐ D. Frequently absent for health reasons  
☐ E. Had to be disciplined in school frequently  
☐ F. Other

68. Describe the child's school behavior in the first grade.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Fearful  
☐ D. Withdrawn  
☐ E. Aggressive  
☐ F. Disobedient  
☐ G. Distractible  
☐ H. Active  
☐ I. Other

69. Describe the child's academic performance in the first grade.

- ☐ A. Does not apply  
☐ B. Excellent grades  
☐ C. Good grades  
☐ D. Average grades  
☐ E. Poor grades

70. Describe the child's experiences in the first grade.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Suspended  
☐ D. Expelled  
☐ E. Frequently absent  
☐ F. Placed in full-time special education class  
☐ G. Placed in part-time special education class  
☐ H. Placed in accelerated academic program  
☐ I. Tutored  
☐ J. Counseled  
☐ K. Evaluated by psychologist  
☐ L. Recommended for retention  
☐ M. Retained  
☐ N. Other

71. Describe the child's academic performance since the first grade.

- ☐ A. Does not apply  
☐ B. Excellent grades  
☐ C. Good grades  
☐ D. Average grades  
☐ E. Poor grades

72. Describe the child's school experiences since the first grade.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Suspended  
☐ D. Expelled  
☐ E. Frequently absent  
☐ F. Placed in full-time special education class  
☐ G. Placed in part-time special education class  
☐ H. Placed in accelerated academic program  
☐ I. Tutored  
☐ J. Counseled  
☐ K. Evaluated by psychologist  
☐ L. Recommended for retention  
☐ M. Retained  
☐ N. Other

73. Describe the child's current subject strengths in school.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Art  
☐ D. Music  
☐ E. Reading  
☐ F. Math  
☐ G. Spelling  
☐ H. English  
☐ I. Science  
☐ J. History  
☐ K. Social Studies  
☐ L. Other

74. Describe the child's current subject weaknesses in school.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Art  
☐ D. Music  
☐ E. Reading  
☐ F. Math  
☐ G. Spelling  
☐ H. English  
☐ I. Science  
☐ J. History  
☐ K. Social Studies  
☐ L. Other

75. Describe the child's current skill strengths in school.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Concentration  
☐ D. Organization  
☐ E. Test preparation  
☐ F. Papers and reports  
☐ G. Handwriting  
☐ H. Memorizing  
☐ I. Paying attention in class  
☐ J. Getting assignments done on time  
☐ K. Being careful and checking work  
☐ L. Vocabulary and expression  
☐ M. Understanding concepts  
☐ N. Pleasing the teacher  
☐ O. Behaving correctly  
☐ P. Taking tests  
☐ Q. Reading speed  
☐ R. Reading comprehension  
☐ S. Spelling  
☐ T. Working hard and not giving up  
☐ U. Intelligence  
☐ V. Other

76. Describe the child's current skill weaknesses in school.

- ☐ A. Does not apply  
☐ B. None  
☐ C. Concentration  
☐ D. Organization  
☐ E. Test preparation  
☐ F. Papers and reports  
☐ G. Handwriting  
☐ H. Memorizing  
☐ I. Paying attention in class  
☐ J. Getting assignments done on time  
☐ K. Being careful and checking work  
☐ L. Vocabulary and expression  
☐ M. Understanding concepts  
☐ N. Pleasing the teacher  
☐ O. Behaving correctly  
☐ P. Taking tests  
☐ Q. Reading speed  
☐ R. Reading comprehension  
☐ S. Spelling  
☐ T. Working hard and not giving up  
☐ U. Intelligence  
☐ V. Other

77. Does the child currently complete homework assignments on time?

- ☐ A. Does not apply  
☐ B. Always  
☐ C. Usually  
☐ D. Rarely  
☐ E. Never

78. Does the child currently require additional academic support (✓✓✓)?
- ☐ A. Does not apply      ☐ F. Extra help from teacher
- ☐ B. No      ☐ G. Perceptual training
- ☐ C. Tutor      ☐ H. Other \_\_\_\_\_
- ☐ D. Remedial class
- ☐ E. Peer tutor
79. Does the child skip school or class?
- ☐ A. Does not apply      ☐ E. More than once per month
- ☐ B. No
- ☐ C. Did so in past, but not currently      ☐ F. Once a week or more
- ☐ D. Less than once per month
80. How often is the child excused from school (for illness, etc.)?
- ☐ A. Does not apply      ☐ D. More than once per month
- ☐ B. Rarely
- ☐ C. Less than once per month      ☐ E. Once a week or more
81. Does the child currently have behavior problems in the classroom (✓✓✓)?
- ☐ A. Does not apply      ☐ F. Often reprimanded
- ☐ B. No      ☐ G. Talks out of turn
- ☐ C. Required to sit near teacher      ☐ H. Can't wait turn
- ☐ D. Required to sit in isolated area      ☐ I. Other \_\_\_\_\_
- ☐ E. Has been sent to principal's office
82. Does the child currently have problems with attention and concentration in the classroom (✓✓✓)?
- ☐ A. Does not apply      ☐ F. Forgets teacher's instructions
- ☐ B. No      ☐ G. Acts without deliberation
- ☐ C. Daydreaming      ☐ H. Difficulty sitting still
- ☐ D. Not getting assignments done      ☐ I. Difficulty being quiet
- ☐ E. Materials disorganized or messy      ☐ J. Other \_\_\_\_\_
83. Describe the child's school behavior since the first grade (✓✓✓).
- ☐ A. Does not apply      ☐ F. Disobedient
- ☐ B. None      ☐ G. Distractible
- ☐ C. Fearful      ☐ H. Active
- ☐ D. Withdrawn      ☐ I. Conflict with teacher
- ☐ E. Aggressive      ☐ J. Other \_\_\_\_\_

84. How is the child described by current teacher(s) (✓✓✓)?

- ☐ A. Does not apply      ☐ J. Switches from one unfinished task to another
- ☐ B. None of the following
- ☐ C. Fidgety      ☐ K. Has problem playing quietly
- ☐ D. Has problem remaining seated      ☐ L. Talks excessively
- ☐ E. Distractible      ☐ M. Interrupts
- ☐ F. Doesn't wait turn in games      ☐ N. Doesn't listen
- ☐ G. Answers questions before completed      ☐ O. Frequently loses objects
- ☐ H. Fails to finish assignments      ☐ P. Fails to consider safety
- ☐ I. Has problem maintaining attention      ☐ Q. Other \_\_\_\_\_

## V. MEDICAL HISTORY AND HEALTH STATUS

85. Which of the following are true (✓✓✓)?
- ☐ A. Do not know      ☐ E. Child has had regular vision tests
- ☐ B. None
- ☐ C. Child has had regular medical checkups      ☐ F. Child has had regular dental checkups
- ☐ D. Child has had regular hearing tests
86. Which of the following are true (✓✓✓)?
- ☐ A. None      ☐ E. Child wears orthopedic or corrective shoes
- ☐ B. Child wears glasses
- ☐ C. Child wears a hearing aid      ☐ F. Child uses crutches for walking
- ☐ D. Child wears an orthopedic brace      ☐ G. Other \_\_\_\_\_
87. Which of the following illnesses or injuries has the child had (✓✓✓)?
- ☐ A. Do not know      ☐ M. Pneumonia
- ☐ B. None      ☐ N. Bronchitis
- ☐ C. Ear infections      ☐ O. Diabetes
- ☐ D. Dehydration      ☐ P. Rheumatic fever
- ☐ E. Hernia      ☐ Q. Tuberculosis
- ☐ F. Measles      ☐ R. Meningitis
- ☐ G. German measles      ☐ S. Broken arm or leg
- ☐ H. Mumps      ☐ T. Serious head injury
- ☐ I. Chicken pox      ☐ U. Allergic reactions
- ☐ J. Tonsillitis      ☐ V. Poisoning
- ☐ K. Polio      ☐ W. Seizures
- ☐ L. Asthma      ☐ X. Other \_\_\_\_\_
88. Has the child ever had a fever over 104 degrees (✓✓✓)?
- ☐ A. Do not know      ☐ F. Yes, treated by a physician
- ☐ B. No
- ☐ C. Yes, for less than 3 hours      ☐ G. Yes, treated in hospital
- ☐ D. Yes, for 3 to 12 hours      ☐ H. Other \_\_\_\_\_
- ☐ E. Yes, for more than 12 hours

89. Which of the following operations has the child had (✓✓✓)?

- ☐ A. None ☐ D. Hernia repair  
☐ B. Appendectomy ☐ E. Other \_\_\_\_\_  
☐ C. Tonsillectomy

90. Is the child currently under medical or psychological care (✓✓✓)?

- ☐ A. No ☐ F. Yes, for seizure control  
☐ B. Yes, for allergies (not asthma) ☐ G. Yes, for Attention Deficit Disorder  
☐ C. Yes, for asthma ☐ H. Yes, for Attention Deficit Hyperactivity Disorder  
☐ D. Yes, for diabetes ☐ I. Other \_\_\_\_\_  
☐ E. Yes, for psychological disorder

91. In the last six months, has there been a change in the child's weight, appetite, or sleep (✓✓✓)?

- ☐ A. No ☐ G. Decrease in appetite  
☐ B. Normal increase in weight and height ☐ H. Loss of appetite  
☐ C. Weight gain ☐ I. Improvement in sleep pattern  
☐ D. Weight loss ☐ J. Change in sleep pattern  
☐ E. Weight loss due to diet ☐ K. Other \_\_\_\_\_  
☐ F. Increase in appetite

92. What problems does the child have with sleep (✓✓✓)?

- ☐ A. None ☐ H. Sleeping enough, but still tired  
☐ B. Trouble getting to sleep ☐ I. Falling asleep in school  
☐ C. Waking up a lot at night ☐ J. Refusing to go to bed  
☐ D. Not getting enough sleep ☐ K. Refusing to get up in morning  
☐ E. Sleeping too much ☐ L. Sleepwalking  
☐ F. Restlessness in bed ☐ M. Nightmares  
☐ G. Waking up too early in the morning ☐ N. Night terrors  
☐ O. Other \_\_\_\_\_

93. What problems does the child have with eating (✓✓✓)?

- ☐ A. None ☐ D. Finicky about food  
☐ B. Refusing to eat ☐ E. Has a poor appetite  
☐ C. Eating too many snacks ☐ F. Overeats  
☐ G. Other \_\_\_\_\_

94. Does the child have problems with wetting or soiling (✓✓✓)?

- ☐ A. No ☐ F. Occasionally wets pants  
☐ B. Occasionally wets bed ☐ G. Frequently wets pants  
☐ C. Frequently wets bed ☐ H. Occasionally soils pants  
☐ D. Occasionally soils bed ☐ I. Frequently soils pants  
☐ E. Frequently soils bed ☐ J. Other \_\_\_\_\_

95. Does the child have frequent physical complaints (✓✓✓)?

- ☐ A. No ☐ D. Yes, complains of muscle aches  
☐ B. Yes, complains of headaches ☐ E. Other \_\_\_\_\_  
☐ C. Yes, complains of stomach aches

## VI. FAMILY HISTORY

96. Which of the following is true about the child's natural mother?

- ☐ A. Does not apply ☐ D. She is alive but in poor health  
☐ B. Do not know if she is alive or deceased ☐ E. She is deceased  
☐ C. She is alive and well

97. Which of the following medical problems has the child's natural mother had (✓✓✓)?

- ☐ A. Does not apply ☐ I. Hypertension (high blood pressure)  
☐ B. Do not know ☐ J. Low back pain  
☐ C. None ☐ K. Problems with lungs or breathing  
☐ D. Arthritis ☐ L. Problems with digestive system  
☐ E. Cancer ☐ M. Other \_\_\_\_\_  
☐ F. Diabetes  
☐ G. Epilepsy (seizures)  
☐ H. Heart problems

98. Which of the following is true about the child's natural father?

- ☐ A. Does not apply ☐ D. He is alive but in poor health  
☐ B. Do not know if he is alive or deceased ☐ E. He is deceased  
☐ C. He is alive and well

99. Which of the following medical problems has the child's natural father had (✓✓✓)?

- ☐ A. Does not apply ☐ I. Hypertension (high blood pressure)  
☐ B. Do not know ☐ J. Low back pain  
☐ C. None ☐ K. Problems with lungs or breathing  
☐ D. Arthritis ☐ L. Problems with digestive system  
☐ E. Cancer ☐ M. Other \_\_\_\_\_  
☐ F. Diabetes  
☐ G. Epilepsy (seizures)  
☐ H. Heart problems

100. Which of the following medical problems have any of the child's natural brothers or sisters had (✓✓✓)?

- ☐ A. Does not apply ☐ I. Hypertension (high blood pressure)  
☐ B. Do not know ☐ J. Low back pain  
☐ C. None ☐ K. Problems with lungs or breathing  
☐ D. Arthritis ☐ L. Problems with digestive system  
☐ E. Cancer ☐ M. Other \_\_\_\_\_  
☐ F. Diabetes  
☐ G. Epilepsy (seizures)  
☐ H. Heart problems

101. Which of the following have been treated for psychological problems (either as an inpatient or outpatient), other than alcohol or drug abuse (✓✓✓)?

- ☐ A. Does not apply ☐ E. Child's natural father  
☐ B. Do not know ☐ F. Child's natural sister  
☐ C. None ☐ G. Child's natural brother  
☐ D. Child's natural mother

102. Which of the following have had problems with alcohol (✓✓✓)?

- ☐ A. Does not apply ☐ E. Child's natural father  
☐ B. Do not know ☐ F. Child's natural sister  
☐ C. None ☐ G. Child's natural brother  
☐ D. Child's natural mother

103. Which of the following have had problems with drugs (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> E. Child's natural father  |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> F. Child's natural sister  |
| <input type="checkbox"/> C. None                   | <input type="checkbox"/> G. Child's natural brother |
| <input type="checkbox"/> D. Child's natural mother |   |
104. Which of the following have had learning problems in school (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> E. Child's natural father  |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> F. Child's natural sister  |
| <input type="checkbox"/> C. None                   | <input type="checkbox"/> G. Child's natural brother |
| <input type="checkbox"/> D. Child's natural mother |   |

## VII. CURRENT BEHAVIOR AND RELATIONSHIPS

105. Describe the relationship between the child and parents (or caretakers).
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Both positive and negative |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Negative                   |
| <input type="checkbox"/> C. Very positive  | <input type="checkbox"/> G. Very negative              |
| <input type="checkbox"/> D. Positive       |  |
106. What kinds of discipline do the child's parents (or caretakers) use (✓✓✓)?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply      | <input type="checkbox"/> G. Withdrawal of privileges |
| <input type="checkbox"/> B. Do not know         | <input type="checkbox"/> H. Grounding                |
| <input type="checkbox"/> C. None                | <input type="checkbox"/> I. Loss of allowance        |
| <input type="checkbox"/> D. Physical punishment | <input type="checkbox"/> J. Other _____              |
| <input type="checkbox"/> E. Yelling             |  |
| <input type="checkbox"/> F. Lectures            |  |
107. How strict are the child's parents (or caretakers)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Average         |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Permissive      |
| <input type="checkbox"/> C. Very strict    | <input type="checkbox"/> G. Very permissive |
| <input type="checkbox"/> D. Strict         |   |
108. Describe the child's responsibilities at home (✓✓✓).
- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply              | <input type="checkbox"/> I. Helping to prepare meals        |
| <input type="checkbox"/> B. Do not know                 | <input type="checkbox"/> J. Helping to clean up after meals |
| <input type="checkbox"/> C. None                        | <input type="checkbox"/> K. Housework                       |
| <input type="checkbox"/> D. Yard work                   | <input type="checkbox"/> L. Cleaning up room                |
| <input type="checkbox"/> E. Baby sitting                | <input type="checkbox"/> M. Other _____                     |
| <input type="checkbox"/> F. Taking out garbage          |   |
| <input type="checkbox"/> G. Doing laundry               |   |
| <input type="checkbox"/> H. Setting the table for meals |   |
109. Does the child receive an allowance?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                     | <input type="checkbox"/> E. Yes, even if the child doesn't do chores |
| <input type="checkbox"/> B. Do not know                        | <input type="checkbox"/> F. Yes, only if the child asks for it       |
| <input type="checkbox"/> C. No                                 | <input type="checkbox"/> G. Other _____                              |
| <input type="checkbox"/> D. Yes, only if the child does chores |  |

110. What rewards or reinforcers do the parents (or caretakers) use to recognize good behavior (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply               | <input type="checkbox"/> J. Computer                |
| <input type="checkbox"/> B. Do not know                  | <input type="checkbox"/> K. Toys                    |
| <input type="checkbox"/> C. None                         | <input type="checkbox"/> L. Books                   |
| <input type="checkbox"/> D. Recognition/praise by father | <input type="checkbox"/> M. Food                    |
| <input type="checkbox"/> E. Recognition/praise by mother | <input type="checkbox"/> N. Snacks and sweets       |
| <input type="checkbox"/> F. Money                        | <input type="checkbox"/> O. Games                   |
| <input type="checkbox"/> G. Television                   | <input type="checkbox"/> P. Outdoor play            |
| <input type="checkbox"/> H. Radio                        | <input type="checkbox"/> Q. Privileges              |
| <input type="checkbox"/> I. Stereo                       | <input type="checkbox"/> R. Recreational activities |
|  | <input type="checkbox"/> S. Other _____             |
111. Describe the child's privileges at home (✓✓✓).
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                               | <input type="checkbox"/> I. Staying home alone when parents go out |
| <input type="checkbox"/> B. None   | <input type="checkbox"/> J. Buying own clothes                     |
| <input type="checkbox"/> C. Playing nearby without supervision           | <input type="checkbox"/> K. Choosing own hair style                |
| <input type="checkbox"/> D. Playing anywhere without supervision         | <input type="checkbox"/> L. Deciding how to spend money            |
| <input type="checkbox"/> E. Going out after dark                         | <input type="checkbox"/> M. Having a friend spend the night        |
| <input type="checkbox"/> F. Using the telephone whenever the child wants | <input type="checkbox"/> N. Spending the night at a friend's house |
| <input type="checkbox"/> G. Determining own curfew                       | <input type="checkbox"/> O. Other _____                            |
| <input type="checkbox"/> H. Determining own bedtime                      |  |
112. How supportive does the child believe his or her parents (or caretakers) are?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply      | <input type="checkbox"/> D. Minimally supportive |
| <input type="checkbox"/> B. Very supportive     | <input type="checkbox"/> E. Not supportive       |
| <input type="checkbox"/> C. Somewhat supportive |  |
113. What things do the child and parents (or caretakers) argue about (✓✓✓)?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply        | <input type="checkbox"/> K. Lying                   |
| <input type="checkbox"/> B. Do not know           | <input type="checkbox"/> L. Music                   |
| <input type="checkbox"/> C. None                  | <input type="checkbox"/> M. Clothes                 |
| <input type="checkbox"/> D. Telephone             | <input type="checkbox"/> N. School                  |
| <input type="checkbox"/> E. Privacy               | <input type="checkbox"/> O. Bedtime                 |
| <input type="checkbox"/> F. Friends               | <input type="checkbox"/> P. Curfew                  |
| <input type="checkbox"/> G. Homework              | <input type="checkbox"/> Q. Spending money          |
| <input type="checkbox"/> H. Etiquette and manners | <input type="checkbox"/> R. Cleanliness and hygiene |
| <input type="checkbox"/> I. Chores                | <input type="checkbox"/> S. Other _____             |
| <input type="checkbox"/> J. Bad language          |   |
114. What kinds of problems do the child's parents (or caretakers) have (✓✓✓)?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply              | <input type="checkbox"/> H. Financial problems             |
| <input type="checkbox"/> B. Do not know                 | <input type="checkbox"/> I. Job problems                   |
| <input type="checkbox"/> C. None                        | <input type="checkbox"/> J. Problems from breaking the law |
| <input type="checkbox"/> D. Problems with health        | <input type="checkbox"/> K. Emotional problems             |
| <input type="checkbox"/> E. Marriage problems           | <input type="checkbox"/> L. Other _____                    |
| <input type="checkbox"/> F. Problems with alcohol abuse |  |
| <input type="checkbox"/> G. Problems with drug abuse    |  |

115. What is the child's attitude toward the parents' separation or divorce (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply                                   | <input type="checkbox"/> H. Blames mother                 |
| <input type="checkbox"/> B. No anticipation of separation or divorce         | <input type="checkbox"/> I. Hopes parents will reunite    |
| <input type="checkbox"/> C. Fears impending separation or divorce            | <input type="checkbox"/> J. Is embarrassed                |
| <input type="checkbox"/> D. Has difficulties relating to father's girlfriend | <input type="checkbox"/> K. Has fears of being abandoned  |
| <input type="checkbox"/> E. Has difficulties relating to mother's boyfriend  | <input type="checkbox"/> L. Is accepting and comfortable  |
| <input type="checkbox"/> F. Blames self                                      | <input type="checkbox"/> M. Has conflicts over visitation |
| <input type="checkbox"/> G. Blames father                                    | <input type="checkbox"/> N. Has conflicts over custody    |
|  | <input type="checkbox"/> O. Other _____                   |
116. Has the child ever been abused by a current member of the household (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> E. Yes, emotionally abused |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> F. Yes, verbally abused    |
| <input type="checkbox"/> C. No                     | <input type="checkbox"/> G. Yes, sexually abused    |
| <input type="checkbox"/> D. Yes, physically abused | <input type="checkbox"/> H. Yes, neglected          |
117. Describe the relationships between the child and brother(s) and/or sister(s).
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Both positive and negative |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Negative                   |
| <input type="checkbox"/> C. Very positive  | <input type="checkbox"/> G. Very negative              |
| <input type="checkbox"/> D. Positive       |  |
118. Describe the child's family relationships (✓✓✓).
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply               | <input type="checkbox"/> E. Unsupportive  |
| <input type="checkbox"/> B. Do not know                  | <input type="checkbox"/> F. Supportive    |
| <input type="checkbox"/> C. Marked by frequent arguments | <input type="checkbox"/> G. Warm, close   |
| <input type="checkbox"/> D. Marked by physical fights    | <input type="checkbox"/> H. Cold, distant |
|  | <input type="checkbox"/> I. Other _____   |
119. How does the child perceive his or her role in the family?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply     | <input type="checkbox"/> D. Somewhat unimportant |
| <input type="checkbox"/> B. Important          | <input type="checkbox"/> E. Unimportant          |
| <input type="checkbox"/> C. Somewhat important |  |
120. How important is religion in the family?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply     | <input type="checkbox"/> E. Somewhat unimportant |
| <input type="checkbox"/> B. Do not know        | <input type="checkbox"/> F. Unimportant          |
| <input type="checkbox"/> C. Important          |  |
| <input type="checkbox"/> D. Somewhat important |  |
121. How much emphasis is placed on achievement by the child's family?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply      | <input type="checkbox"/> D. Emphasized     |
| <input type="checkbox"/> B. Do not know         | <input type="checkbox"/> E. Not emphasized |
| <input type="checkbox"/> C. Strongly emphasized | <input type="checkbox"/> F. Ignored        |
122. Which of the following describes the child now?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Has many close friends    | <input type="checkbox"/> C. Has few close friends |
| <input type="checkbox"/> B. Has several close friends | <input type="checkbox"/> D. Has no close friends  |
123. How does the child perceive his or her level of acceptance by peers?
- |                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> A. Good  | <input type="checkbox"/> C. Poor |
| <input type="checkbox"/> B. Mixed |                                  |

124. Which problems does the child have with peers (✓✓✓)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. None                         | <input type="checkbox"/> G. Having peers who engage in delinquent behavior |
| <input type="checkbox"/> B. Being teased                 | <input type="checkbox"/> H. Having peers get better grades                 |
| <input type="checkbox"/> C. Being physically attacked    | <input type="checkbox"/> I. Having peers get poorer grades                 |
| <input type="checkbox"/> D. Having frequent arguments    | <input type="checkbox"/> J. Other _____                                    |
| <input type="checkbox"/> E. Being rejected by peer group |  |
| <input type="checkbox"/> F. Being jealous of peers       |  |
125. How is the child's self-esteem?
- |   |   |
|---|---|
| <input type="checkbox"/> A. Very positive | <input type="checkbox"/> D. Negative      |
| <input type="checkbox"/> B. Positive      | <input type="checkbox"/> E. Very negative |
| <input type="checkbox"/> C. Mixed         |   |
126. How is the child's adjustment to his or her age?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Satisfied with age | <input type="checkbox"/> C. Wants to be younger |
| <input type="checkbox"/> B. Wants to be older  |   |
127. Describe the child's awareness and knowledge of sex (✓✓✓).
- |   |  |
|---|--|
| <input type="checkbox"/> A. Prefer not to answer            | <input type="checkbox"/> E. Overly mature regarding sexual matters |
| <input type="checkbox"/> B. Not aware or knowledgeable      | <input type="checkbox"/> F. Avoids sexual matters                  |
| <input type="checkbox"/> C. Aware of reproduction facts     | <input type="checkbox"/> G. Other _____                            |
| <input type="checkbox"/> D. Comfortable with sexual matters |  |
128. Has the child expressed a desire to be the opposite sex?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Prefer not to answer           | <input type="checkbox"/> D. Yes, currently |
| <input type="checkbox"/> B. Never                          |  |
| <input type="checkbox"/> C. At one time, but not currently |  |
129. What are the child's hobbies (✓✓✓)?
- |   |   |
|---|---|
| <input type="checkbox"/> A. None              | <input type="checkbox"/> E. Art         |
| <input type="checkbox"/> B. Collecting things | <input type="checkbox"/> F. Music       |
| <input type="checkbox"/> C. Building things   | <input type="checkbox"/> G. Other _____ |
| <input type="checkbox"/> D. Reading           |   |
130. How does the child usually spend his or her play time (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Alone  | <input type="checkbox"/> E. Other _____ |
| <input type="checkbox"/> B. With peers                                   |   |
| <input type="checkbox"/> C. With family                                  |   |
| <input type="checkbox"/> D. In organized activities (clubs, scouts, etc) |   |
131. How does the child participate in games with others (✓✓✓)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not participate   | <input type="checkbox"/> F. Has a strong drive to win  |
| <input type="checkbox"/> B. Actively participates  | <input type="checkbox"/> G. Has no interest in winning |
| <input type="checkbox"/> C. Passively participates | <input type="checkbox"/> H. Other _____                |
| <input type="checkbox"/> D. Cheats occasionally    |  |
| <input type="checkbox"/> E. Cheats regularly       |  |
132. Does the child have imaginary playmates?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Never has had                | <input type="checkbox"/> C. Has currently |
| <input type="checkbox"/> B. Has had in past, but not now |   |

133. Does the child participate in sports (✓✓✓)?
- |   |   |
|---|---|
| <input type="checkbox"/> A. No  | <input type="checkbox"/> D. Yes, in individual sports (hiking, running, etc.) |
| <input type="checkbox"/> B. Yes, in organized sports (school, league, etc.) |   |
| <input type="checkbox"/> C. Yes, in neighborhood games                      |   |

134. Describe the child's independent activities (✓✓✓)?
- |   |  |
|---|--|
| <input type="checkbox"/> A. None                                | <input type="checkbox"/> K. Goes to school by self         |
| <input type="checkbox"/> B. Sleeps at friend's house            | <input type="checkbox"/> L. Goes shopping without parents  |
| <input type="checkbox"/> C. Has been to overnight camp          | <input type="checkbox"/> M. Goes to movies without parents |
| <input type="checkbox"/> D. Stays with babysitter               | <input type="checkbox"/> N. Stays outside after dark       |
| <input type="checkbox"/> E. Goes to friend's house alone        | <input type="checkbox"/> O. Gets dressed without help      |
| <input type="checkbox"/> F. Goes to bed alone                   | <input type="checkbox"/> P. Takes bath without help        |
| <input type="checkbox"/> G. Does not use night light            | <input type="checkbox"/> Q. Responsible for own chores     |
| <input type="checkbox"/> H. Stays out of parents' room at night | <input type="checkbox"/> R. Other _____                    |
| <input type="checkbox"/> I. Does not have a special blanket     |  |
| <input type="checkbox"/> J. Chooses clothes to wear             |  |

135. Which of the following has the child experienced in the past year (✓✓✓)?
- |  |   |
|--|---|
| <input type="checkbox"/> A. None   | <input type="checkbox"/> F. Parents' separation                   |
| <input type="checkbox"/> B. Mother getting pregnant                          | <input type="checkbox"/> G. Parents' divorce                      |
| <input type="checkbox"/> C. Birth of brother or sister                       | <input type="checkbox"/> H. Parent being seriously ill or injured |
| <input type="checkbox"/> D. Brother or sister being seriously ill or injured | <input type="checkbox"/> I. Death of a parent                     |
| <input type="checkbox"/> E. Death of a brother or sister                     | <input type="checkbox"/> J. Parent losing job                     |
|  | <input type="checkbox"/> K. Change of schools                     |
|  | <input type="checkbox"/> L. Move to a new home                    |
|  | <input type="checkbox"/> M. Other _____                           |

136. How would you describe the child now (✓✓✓)?
- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> A. Active   | <input type="checkbox"/> K. Shy         |
| <input type="checkbox"/> B. Passive  | <input type="checkbox"/> L. Lonely      |
| <input type="checkbox"/> C. Happy    | <input type="checkbox"/> M. Quiet       |
| <input type="checkbox"/> D. Content  | <input type="checkbox"/> N. Noisy       |
| <input type="checkbox"/> E. Unhappy  | <input type="checkbox"/> O. Coordinated |
| <input type="checkbox"/> F. Calm     | <input type="checkbox"/> P. Clumsy      |
| <input type="checkbox"/> G. Nervous  | <input type="checkbox"/> Q. Intelligent |
| <input type="checkbox"/> H. Fearful  | <input type="checkbox"/> R. Dull        |
| <input type="checkbox"/> I. Moody    | <input type="checkbox"/> S. Other _____ |
| <input type="checkbox"/> J. Outgoing |   |

Notes:

Additional copies available from:

**PAR** Psychological Assessment Resources, Inc.  
P.O. Box 998/Odessa, Florida 33556/Toll-Free 1-800-331-TEST





## Comprehensive Holistic Health & House Calls

**Lynne Odell-Holzer, MSN, FNP, NPP**

Registered Nurse Practitioner in Family Medicine & Psychiatry

315-622-9241 Voice & Fax

hhh@holzerent.com

### WELCOME TO COMPREHENSIVE HOLISTIC HEALTH & HOUSE CALLS

#### Who We Are:

Comprehensive Holistic Health & House Calls (CHHHC) is an organization of Nurse Practitioners who primarily provide medical type house calls. As Nurse Practitioners, we can provide various combinations of health services for people primarily in the person's own home. (It is easy to do so, but we are not to be confused with a visiting nurse service). As Nurse Practitioners we have advanced training that prepares us to offer the full range of basic physical and health care services usually found in a primary care provider's office. These include histories and physicals, follow up on many common physical and mental health conditions (from Attention Deficit Disorder to Zoster!), and treatment including prescriptions. In situations where you have chosen the NP to be your primary physical health care provider, the NP will collaborate with his/her physicians for any situations that might be beyond that NP's scope of practice. In situations where you have chosen the NP from CHHHC to be an adjunct to your current health care provider, because you cannot get to the office, the NP will coordinate with your usual primary care provider.

Please note: we are a mobile primary care service, NOT an emergency service. If you believe you are having a condition that cannot wait, call 911 for emergency help.

#### Our Philosophy:

We believe that people are integrated, complex, beings who work hard to feel comfortable and to improve their lives. We believe that people are whole, complex beings in whom the mind and the body affect each other intimately. We believe that each person is a complete individual living and growing in the context of their environment and their genetic endowments. We further believe that there are times when people cannot effectively maintain their innate abilities. At those times, people may benefit from our evaluation, management, treatment, education and referral to reach or return to independence and maximum function.

As a medically based health care service established to provide both mental and physical medical care, we use health principles of Western medicine to 1) prevent dysfunction, 2) prevent complications from an unavoidable dysfunction, or 3) restore as much function as possible. Since an estimated 20% of the US population utilizes alternative, herbal, or non-Western health therapies, we have developed a familiarity with most of them. This way we can coordinate, teach, or refer those self-help strategies to safely combine them with traditional Western health care methods. We support and encourage self-help, self-determination, and independence of the individual. With that philosophy in mind, you can see why we expect that the person being 'treated' takes an active part to best meet this goal. We operate on a strengths-based philosophy. We strive to use what capacities the 'patient' already has to attain maximum health and function.

#### What We Do:

We provide a full range of primary health care on a mobile basis to meet the person (patient) where the person best functions —the home. We are nurse practitioners trained to provide primary uncomplicated acute and chronic stable health care to people of any age. Due to the state of portable technology, we are not always able to provide the full range of testing found in the traditional primary health care office. If a test is required that cannot be performed on site, the CHHHC staff will help you arrange for testing in alternative sites. If you already have an office based primary health care provider, we will be glad to work as an adjunct with your provider if he/she wishes. Please note that although home delivered medical services are expensive in terms of time, *your current health care provider may already provide house calls under some circumstances.* It would be useful for you to *ask your current health care provider if this service is available before requesting CHHHC.* If you use our services, we will also request Releases of Information to coordinate our services with your other health care providers.

#### 24 Hour Coverage:

We are available for 24 hour coverage in the rare event that you have a health question that cannot wait for usual office hours. The number is on the business card your Nurse Practitioner leaves. If you believe that your health is deteriorating rapidly (i. e., within hours), please be seen in the local walk-in clinic or emergency room as soon as possible. While we may be able to give some general advice over the phone, we do not have capacity for emergency house calls.

Cost:

Since we are medically based and operate much like the "country doctor" of old, we are able to utilize most health insurances. We will accept assignment of benefits unless you choose not. We also try hard to keep the cost of health care down. Therefore, the 'patient' or responsible party will be expected to pay the copay or any non-covered services at the time of service so we don't have to pay billing & collection services. Since some insurances will not cover our type of services, please call the office manager & billing person at 423-4152 or [hgreenier@aol.com](mailto:hgreenier@aol.com) for clarification of any insurance coverage or charge questions before a visit is scheduled.

We also request as much advance notice as possible if there needs to be a cancellation of services. If cancellation under 24 hours is unavoidable, we may have to charge a 50% fee to recover some of our lost time and unavailability to our other patients.

Confidentiality:

All of your records are considered confidential and will only be released with your advance knowledge and for the express purposes of your insurances, or as required by a court of law. At other times, CHHHC will request records and information to be sent/received with other health care providers involved in your situation. Your consent is requested in order to coordinate services and a signature to that effect is required below. You will be told of the purpose of these requests at the time they occur. You can expect your personal information to be kept under the strictest confidence and only what is absolutely necessary divulged when required. This is in full compliance with HIPAA requirements at all times.

Statements of Agreement and Consent:

By the signature(s) below, I/we state that I/we have read, understand and agree with the conditions of treatment by the staff of CHHHC as stated above.

By the signature(s) below, I/we state that I/we have read, understand and agree to authorize CHHHC professionals to administer evaluate, and manage my/our health, including treatments or prescriptions. I/we have been informed of the nature, purpose, alternatives and risks of the proposed treatments and have had an opportunity to participate in the treatment planning.

I/we have had an opportunity to discuss Advance Directive, Living Will, Health Care Proxy and Do Not Resuscitate information with a CHHHC representative and I/we have made my/our wishes known to CHHHC.

I/we authorize release of pertinent health records by other health care providers to CHHHC necessary for the appropriate and safe health care delivery. These records may include, but are not limited to, examination and progress notes, X-rays, photographs, reports, charts and other information pertinent to my/our ongoing health care.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Signature of Responsible Party/Relationship

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

(original signature page to CHHHC record. Copy of page 2 + first page to patient/representative)

Cost:

Since we are medically based and operate much like the "country doctor" of old, we are able to utilize most health insurances. We will accept assignment of benefits unless you choose not. We also try hard to keep the cost of health care down. Therefore, the 'patient' or responsible party will be expected to pay the copay or any non-covered services at the time of service so we don't have to pay billing & collection services. Since some insurances will not cover our type of services, please call the office manager & billing person at 423-4152 or [hgreenier@aol.com](mailto:hgreenier@aol.com) for clarification of any insurance coverage or charge questions before a visit is scheduled.

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Signature of Responsible Party/Relationship

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

(original signature page to CHHHC record. Copy of page 2 + first page to patient/representative)

# Parenting Stress

What Can I Do to Help My Child?

21

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

## Parents' Stress

- \_\_\_ 1. I feel overwhelmed with responsibilities.
- \_\_\_ 2. I feel depressed and unhappy.
- \_\_\_ 3. I am physically unhealthy.
- \_\_\_ 4. It seems like I am not taking care of myself.
- \_\_\_ 5. I use drugs and/or alcohol too often.
- \_\_\_ 6. I have recently experienced stressful life events (e.g., loss of job, death of significant person, divorce, etc.).
- \_\_\_ 7. My spouse/partner and I don't communicate (if applicable).
- \_\_\_ 8. My child is very difficult to discipline.
- \_\_\_ 9. My spouse/partner and I don't agree on parenting issues (if applicable).
- \_\_\_ 10. I feel like I have no support and I am all alone.
- \_\_\_ Total score

## Parents' Thoughts

- \_\_\_ 11. I often have the thought, "My child is behaving like a brat."
- \_\_\_ 12. I often have the thought, "My child does it on purpose."
- \_\_\_ 13. I often have the thought, "My child is the cause of all our family problems."
- \_\_\_ 14. I often have the thought, "If I wasn't such a poor parent, my child would be better off."
- \_\_\_ 15. I often have the thought, "It is his/her fault (other parent/guardian) that my child is this way."
- \_\_\_ 16. I often have the thought, "My child's future is bleak; he/she will probably be irresponsible, a criminal, a high school dropout (etc.) when grown up."
- \_\_\_ 17. I often have the thought, "My child should behave like other children; I shouldn't have to teach my child how to behave."
- \_\_\_ 18. I often have the thought, "Our family is a mess."
- \_\_\_ 19. I often have the thought, "I give up; there is nothing more I can do for my child."
- \_\_\_ 20. I often have the thought, "I have no control over my child, I've tried everything, nothing seems to work."
- \_\_\_ Total score

## Parental Involvement and Positive Reinforcement

- \_\_\_ 21. I don't pay much attention to my child's good behavior.
- \_\_\_ 22. I don't praise my child as much as I could.
- \_\_\_ 23. I have more negative interactions than positive interactions with my child.



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- \_\_\_\_\_ 24. I probably give my child more attention when he/she acts negatively than when he/she acts positively.
- \_\_\_\_\_ 25. I'm too busy and spend little time with my child.
- \_\_\_\_\_ 26. When I'm with my child, I'm usually doing things (e.g., cleaning, running errands, shopping, etc.) and not really paying attention to him/her.
- \_\_\_\_\_ 27. I'm not involved in my child's activities (e.g., school, athletics, scouts, etc.).
- \_\_\_\_\_ 28. My child and I are not very close to each other.
- \_\_\_\_\_ 29. My child and I are emotionally disconnected.
- \_\_\_\_\_ 30. I'm too stressed out and tired to spend "quality" time with my child.
- \_\_\_\_\_ Total score

#### Family Interactions

- \_\_\_\_\_ 31. We are seldom aware of when we are having communication problems.
- \_\_\_\_\_ 32. We express ourselves in "unhelpful" ways (e.g., put-downs, blaming, interrupting, talking on and on, etc.).
- \_\_\_\_\_ 33. We are not good at listening to each other (e.g., making poor eye contact, daydreaming, thinking about what one is going to say without listening to the other person, etc.).
- \_\_\_\_\_ 34. We often communicate different messages on verbal and nonverbal levels (e.g., saying, "I love you," in a loud, screaming voice while pounding one's fist on a table).
- \_\_\_\_\_ 35. We have difficulty recognizing and defining family problems.
- \_\_\_\_\_ 36. Our family uses the same solutions over and over, and we don't think of new ways to solve our problems.
- \_\_\_\_\_ 37. We don't think ahead about whether a solution to a problem might work.
- \_\_\_\_\_ 38. We may figure out a good solution to a family problem, but we usually don't follow through and use it.
- \_\_\_\_\_ 39. We usually don't recognize when anger and conflict are becoming destructive.
- \_\_\_\_\_ 40. We rarely know how to control anger and conflict, and it gets out of hand in our family.
- \_\_\_\_\_ Total score

#### Discipline Related to Compliance and Rule Following in Children

- \_\_\_\_\_ 41. I give in and allow my child to "get his/her way" because he/she is so difficult and belligerent.
- \_\_\_\_\_ 42. It's easier to do things myself rather than ask my child to do them.
- \_\_\_\_\_ 43. I have to yell, threaten, and so forth to get my child to do anything.
- \_\_\_\_\_ 44. My child and I have power struggles.
- \_\_\_\_\_ 45. I am inconsistent in disciplining approaches.
- \_\_\_\_\_ 46. My spouse/partner and I don't agree on discipline approaches (if applicable).

- \_\_\_ 47. I seem to "tune into" my child the most when he/she is acting negatively.
- \_\_\_ 48. I often don't know where my child is or what he/she is doing.
- \_\_\_ 49. I have no clear rules established at my home.
- \_\_\_ 50. There is no set time for curfew, bedtime, homework, and so forth.
- \_\_\_ Total score

#### Children's Social Behavior Skills

- \_\_\_ 51. My child doesn't have good eye contact with other children.
- \_\_\_ 52. My child has difficulty expressing feelings appropriately to other children.
- \_\_\_ 53. My child doesn't share with other children.
- \_\_\_ 54. My child doesn't know how to cooperate very well with other children.
- \_\_\_ 55. My child doesn't know how to start conversations with other children.
- \_\_\_ 56. My child is passive with other children.
- \_\_\_ 57. My child is aggressive with other children.
- \_\_\_ 58. My child doesn't ask questions of other children.
- \_\_\_ 59. My child doesn't listen to other children.
- \_\_\_ 60. My child doesn't ignore other children when he/she should.
- \_\_\_ Total score

#### Children's Social and General Problem-Solving Skills

- \_\_\_ 61. My child doesn't think about what he/she is doing.
- \_\_\_ 62. My child gets into trouble because of not thinking ahead about consequences of behavior.
- \_\_\_ 63. My child doesn't work toward a goal.
- \_\_\_ 64. My child seems unaware when he/she is having a problem.
- \_\_\_ 65. My child does the same thing over and over, even though it doesn't work to solve problems.
- \_\_\_ 66. My child doesn't use good strategies to solve problems.
- \_\_\_ 67. My child doesn't know when he/she is having a social problem.
- \_\_\_ 68. My child is unaware of his/her effect on others.
- \_\_\_ 69. My child doesn't use good strategies to solve interpersonal difficulties.
- \_\_\_ 70. My child uses primarily aggressive solutions to solve disagreements with others.
- \_\_\_ Total score

#### Children's Ability to Cope with Anger

- \_\_\_ 71. My child has an anger problem.
- \_\_\_ 72. My child gets upset very easily.
- \_\_\_ 73. My child is unaware when he/she is getting angry or frustrated.
- \_\_\_ 74. My child destroys or damages personal or others' belongings/property.
- \_\_\_ 75. My child is violent toward others.
- \_\_\_ 76. My child blows up and has anger outbursts.

- \_\_\_\_\_ 77. My child is easily frustrated.
- \_\_\_\_\_ 78. My child tends to be irritable and cranky.
- \_\_\_\_\_ 79. I get angry at my child too much.
- \_\_\_\_\_ 80. I have an anger problem.
- \_\_\_\_\_ Total score

#### Children's Ability to Engage in Self-Directed Academic Behaviors

- \_\_\_\_\_ 81. My child is unable to organize school materials.
- \_\_\_\_\_ 82. My child doesn't effectively budget his/her time.
- \_\_\_\_\_ 83. My child often doesn't know what homework is supposed to be done.
- \_\_\_\_\_ 84. My child is usually off-task and doesn't get work done at school.
- \_\_\_\_\_ 85. My child is usually off-task and doesn't get homework done at home.
- \_\_\_\_\_ 86. My child has poor study skills and habits.
- \_\_\_\_\_ 87. My child doesn't have a routine time and place set up for homework in our home.
- \_\_\_\_\_ 88. I don't really know why my child is having problems at school.
- \_\_\_\_\_ 89. I am uninvolved in my child's schooling.
- \_\_\_\_\_ 90. I don't work closely with my child's teacher.
- \_\_\_\_\_ Total score

#### Children's Emotional Well-Being and Level of Self-Esteem

- \_\_\_\_\_ 91. My child doesn't understand his/her own emotional experience.
- \_\_\_\_\_ 92. My child tends to deny his/her feelings.
- \_\_\_\_\_ 93. My child doesn't express feelings very well.
- \_\_\_\_\_ 94. My child doesn't tell anyone about his/her troubles.
- \_\_\_\_\_ 95. My child tends to think negative thoughts.
- \_\_\_\_\_ 96. My child doesn't like him/herself.
- \_\_\_\_\_ 97. My child tends to think things are awful.
- \_\_\_\_\_ 98. My child focuses on the negative and loses sight of the positive.
- \_\_\_\_\_ 99. My child tends to blame him/herself for too many problems.
- \_\_\_\_\_ 100. My child puts him/herself down a lot (e.g., says negative things about him/herself).
- \_\_\_\_\_ Total score

Review your answers to the above questions carefully. Total up the score within each of the ten areas of focus and indicate the total score where designated above. Those areas of focus with higher scores may indicate problem areas for yourself, your family, and/or your child. Those questions that were rated as a 3, 4, or 5 may indicate specific problems.

### DECIDING ON A FOCUS

In the space below, rank the ten areas of focus, putting the area with the highest score at the top, going down to the second highest score, and so forth until you've ranked all ten areas of focus.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

By ranking the ten areas of focus by their scores, you are making use of "scientific method." Now examine the list again, and use your "gut reaction" to rank the areas according to those you think are the most important to focus on. **Keep in mind that it is usually less effective to focus on child skills if the parent or family is having problems. Instead, focus on parent and/or family skills before going on to child skills.** List below the final selection and order of the problems according to what you perceive to be the most important area down to the least important.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

### HOW TO USE THIS BOOK

Listed below are chapters in this book that are related to the ten areas of focus:

Area	Chapter
Parents' Stress	3
Parents' Thoughts	4
Parental Involvement and Positive Reinforcement	5
Family Interactions	6
Discipline Related to Compliance and Rule Following in Children	7, 8
Children's Social Behavior Skills	9
Children's Social and General Problem-Solving Skills	10
Children's Ability to Cope with Anger	11
Children's Self-Directed Academic Behavior	12
Children's Emotional Well-Being and Self-Esteem	13, 14, 15



- ☐ Personal  
☐ History  
☐ Checklist  
☐ for Adolescents  
☒



Comprehensive Holistic Health & House Calls

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Registered Nurse Practitioner in Family Health & Psychiatry

Primary physical and mental health care  
delivered in your home

Health & Illness Treatment & Education

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Edward H. Dougherty, Ph.D.  
John A. Schinka, Ph.D.

Name \_\_\_\_\_  
Last First Initial

Age \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_\_

Completed by \_\_\_\_\_

### DIRECTIONS

This checklist asks questions about your personal history and current life. Begin by entering your name, age, sex, and the date at the top of this page. Then turn to the inside of this booklet and answer the questions. All of the questions are numbered in order. For each question, make a mark (X) next to the answer that describes your history or current life. Many questions have a space labeled *Other* for writing in an answer if the correct answer is not provided. Questions followed by the symbol (///) should be marked with all the answers that apply. For questions that do not apply, mark the answer *Does not apply*.

#### EXAMPLE

14. Where do you live?

- |   |   |
|---|---|
| <input type="checkbox"/> A. House       | <input type="checkbox"/> E. Boarding school |
| <input type="checkbox"/> B. Apartment   | <input type="checkbox"/> F. Agency housing  |
| <input type="checkbox"/> C. Trailer     | <input type="checkbox"/> G. Institution     |
| <input type="checkbox"/> D. Condominium | <input type="checkbox"/> H. Other _____     |

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## I. PRESENTING INFORMATION

1. What is your race?
 

<input type="checkbox"/> A. White	<input type="checkbox"/> E. Asian
<input type="checkbox"/> B. Black	<input type="checkbox"/> F. Native American
<input type="checkbox"/> C. Oriental	<input type="checkbox"/> G. Other _____
<input type="checkbox"/> D. Hispanic	
2. Who referred you here, or recommended that you come here?
 

<input type="checkbox"/> A. No one, came by yourself	<input type="checkbox"/> G. A community agency
<input type="checkbox"/> B. A friend	<input type="checkbox"/> H. A priest, pastor, or other religious staff person
<input type="checkbox"/> C. Your parents	<input type="checkbox"/> I. The police
<input type="checkbox"/> D. Your pediatrician	<input type="checkbox"/> J. A judge
<input type="checkbox"/> E. Your family doctor	<input type="checkbox"/> K. Other _____
<input type="checkbox"/> F. Your school	
3. What is the main problem that led to your coming here?
 

<input type="checkbox"/> A. Have no problem	<input type="checkbox"/> M. Problems with job
<input type="checkbox"/> B. Depression	<input type="checkbox"/> N. Problems with school grades
<input type="checkbox"/> C. Thinking about killing yourself	<input type="checkbox"/> O. Problems with school behavior
<input type="checkbox"/> D. Trying to kill yourself	<input type="checkbox"/> P. Problems with alcohol
<input type="checkbox"/> E. Anxiety	<input type="checkbox"/> Q. Problems with drugs
<input type="checkbox"/> F. Weight problems	<input type="checkbox"/> R. Health problem
<input type="checkbox"/> G. Problems with thinking clearly	<input type="checkbox"/> S. Facing criminal charges
<input type="checkbox"/> H. Arguments with parents	<input type="checkbox"/> T. Being physically abused
<input type="checkbox"/> I. Parents' divorce	<input type="checkbox"/> U. Being sexually abused
<input type="checkbox"/> J. Parents' separation	<input type="checkbox"/> V. Other _____
<input type="checkbox"/> K. Parents' conflict over custody	
<input type="checkbox"/> L. Parents' conflict over visitation	
4. In your own opinion, how severe is this problem?
 

<input type="checkbox"/> A. Does not apply	<input type="checkbox"/> C. Moderate
<input type="checkbox"/> B. Mild	<input type="checkbox"/> D. Severe
5. How long have you had this problem?
 

<input type="checkbox"/> A. Does not apply	<input type="checkbox"/> E. For the past year
<input type="checkbox"/> B. For the past several days	<input type="checkbox"/> F. For the past two years
<input type="checkbox"/> C. For the past several weeks	<input type="checkbox"/> G. For the past several years
<input type="checkbox"/> D. For the past several months	
6. Which of the following has this problem affected (✓/✓/✓)?
 

<input type="checkbox"/> A. Does not apply	<input type="checkbox"/> F. Your relationships with your brothers and sisters
<input type="checkbox"/> B. None	<input type="checkbox"/> G. Your relationship with your parents
<input type="checkbox"/> C. Your performance at school	<input type="checkbox"/> H. Your health
<input type="checkbox"/> D. Your performance at work	<input type="checkbox"/> I. Other _____
<input type="checkbox"/> E. Your relationships with friends	

7. Have you been treated for this problem before?
 

<input type="checkbox"/> A. Does not apply	<input type="checkbox"/> E. Yes, but without success
<input type="checkbox"/> B. No	<input type="checkbox"/> F. Yes, but did not want to cooperate then
<input type="checkbox"/> C. Yes, with success	
<input type="checkbox"/> D. Yes, but with only partial success	
8. What other problems are you having (✓/✓/✓)?
 

<input type="checkbox"/> A. None	<input type="checkbox"/> M. Problems with job
<input type="checkbox"/> B. Depression	<input type="checkbox"/> N. Problems with school grades
<input type="checkbox"/> C. Thinking about killing yourself	<input type="checkbox"/> O. Problems with school behavior
<input type="checkbox"/> D. Trying to kill yourself	<input type="checkbox"/> P. Problems with alcohol
<input type="checkbox"/> E. Anxiety	<input type="checkbox"/> Q. Problems with drugs
<input type="checkbox"/> F. Weight problems	<input type="checkbox"/> R. Health problem
<input type="checkbox"/> G. Problems with thinking clearly	<input type="checkbox"/> S. Facing criminal charges
<input type="checkbox"/> H. Arguments with parents	<input type="checkbox"/> T. Being physically abused
<input type="checkbox"/> I. Parents' divorce	<input type="checkbox"/> U. Being sexually abused
<input type="checkbox"/> J. Parents' separation	<input type="checkbox"/> V. Other _____
<input type="checkbox"/> K. Parents' conflict over custody	
<input type="checkbox"/> L. Parents' conflict over visitation	

## II. PERSONAL INFORMATION AND FAMILY BACKGROUND

9. What is your status in school now?
 

<input type="checkbox"/> A. Full-time, regular classes	<input type="checkbox"/> J. Dropped out because of discipline problems
<input type="checkbox"/> B. Part-time, regular classes	<input type="checkbox"/> K. Dropped out to work to support family
<input type="checkbox"/> C. Full-time, special education classes	<input type="checkbox"/> L. Dropped out because of drug problems
<input type="checkbox"/> D. Part-time, special education classes	<input type="checkbox"/> M. Dropped out because of health problems
<input type="checkbox"/> E. Suspended from school	<input type="checkbox"/> N. Dropped out because you got pregnant
<input type="checkbox"/> F. Expelled from school	<input type="checkbox"/> O. Dropped out because girlfriend got pregnant
<input type="checkbox"/> G. Being tutored at home	<input type="checkbox"/> P. Other _____
<input type="checkbox"/> H. On summer vacation	
<input type="checkbox"/> I. Dropped out because of poor grades	
10. What grade are you in now (or when school starts again in the fall)?
 

<input type="checkbox"/> A. Not attending school	<input type="checkbox"/> F. Ninth
<input type="checkbox"/> B. Fifth	<input type="checkbox"/> G. Tenth
<input type="checkbox"/> C. Sixth	<input type="checkbox"/> H. Eleventh
<input type="checkbox"/> D. Seventh	<input type="checkbox"/> I. Twelfth
<input type="checkbox"/> E. Eighth	

11. What type of school do you attend?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Not attending school       | <input type="checkbox"/> F. Orphanage school |
| <input type="checkbox"/> B. Public school              | <input type="checkbox"/> G. Military academy |
| <input type="checkbox"/> C. Private school             | <input type="checkbox"/> H. Boarding school  |
| <input type="checkbox"/> D. Parochial school           | <input type="checkbox"/> I. Other _____      |
| <input type="checkbox"/> E. School for the handicapped |  |

12. What is your employment status?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Employed full-time                | <input type="checkbox"/> D. Not employed, not looking for job |
| <input type="checkbox"/> B. Employed part-time                | <input type="checkbox"/> E. Other _____                       |
| <input type="checkbox"/> C. Unemployed, but looking for a job |   |

13. Who do you live with?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Natural parents               | <input type="checkbox"/> H. Aunt and uncle                   |
| <input type="checkbox"/> B. Natural father                | <input type="checkbox"/> I. Adoptive parents                 |
| <input type="checkbox"/> C. Natural mother                | <input type="checkbox"/> J. Foster parents                   |
| <input type="checkbox"/> D. Natural father and stepmother | <input type="checkbox"/> K. Live in an orphanage             |
| <input type="checkbox"/> E. Natural mother and stepfather | <input type="checkbox"/> L. Live in an agency                |
| <input type="checkbox"/> F. Grandparents on father's side | <input type="checkbox"/> M. Live in a charitable institution |
| <input type="checkbox"/> G. Grandparents on mother's side | <input type="checkbox"/> N. Other _____                      |

14. Where do you live?

- |   |   |
|---|---|
| <input type="checkbox"/> A. House       | <input type="checkbox"/> E. Boarding school |
| <input type="checkbox"/> B. Apartment   | <input type="checkbox"/> F. Agency housing  |
| <input type="checkbox"/> C. Trailer     | <input type="checkbox"/> G. Institution     |
| <input type="checkbox"/> D. Condominium | <input type="checkbox"/> H. Other _____     |

15. Who primarily raised you?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Natural parents               | <input type="checkbox"/> H. Aunt and uncle         |
| <input type="checkbox"/> B. Natural father                | <input type="checkbox"/> I. Aunt                   |
| <input type="checkbox"/> C. Natural mother                | <input type="checkbox"/> J. Uncle                  |
| <input type="checkbox"/> D. Natural father and stepmother | <input type="checkbox"/> K. Older brother          |
| <input type="checkbox"/> E. Natural mother and stepfather | <input type="checkbox"/> L. Older sister           |
| <input type="checkbox"/> F. Grandparents on father's side | <input type="checkbox"/> M. Adoptive parents       |
| <input type="checkbox"/> G. Grandparents on mother's side | <input type="checkbox"/> N. Foster parents         |
|   | <input type="checkbox"/> O. Orphanage              |
|   | <input type="checkbox"/> P. Charitable institution |
|   | <input type="checkbox"/> Q. Other _____            |

16. How many children are in your family?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply        | <input type="checkbox"/> H. 7 including yourself            |
| <input type="checkbox"/> B. You are an only child | <input type="checkbox"/> I. 8 including yourself            |
| <input type="checkbox"/> C. 2 including yourself  | <input type="checkbox"/> J. 9 including yourself            |
| <input type="checkbox"/> D. 3 including yourself  | <input type="checkbox"/> K. 10 including yourself           |
| <input type="checkbox"/> E. 4 including yourself  | <input type="checkbox"/> L. More than 10 including yourself |
| <input type="checkbox"/> F. 5 including yourself  |   |
| <input type="checkbox"/> G. 6 including yourself  |   |

17. Of the other children in your family, how many are stepbrothers and stepsisters?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> G. 5           |
| <input type="checkbox"/> B. None           | <input type="checkbox"/> H. 6           |
| <input type="checkbox"/> C. 1              | <input type="checkbox"/> I. 7           |
| <input type="checkbox"/> D. 2              | <input type="checkbox"/> J. 8           |
| <input type="checkbox"/> E. 3              | <input type="checkbox"/> K. More than 8 |
| <input type="checkbox"/> F. 4              |   |

18. Which child are you?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply, you are an only child | <input type="checkbox"/> C. A middle child   |
| <input type="checkbox"/> B. The youngest child                    | <input type="checkbox"/> D. The oldest child |
|   | <input type="checkbox"/> E. Other _____      |

19. How much education did your father complete?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> G. Some college     |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> H. College graduate |
| <input type="checkbox"/> C. Less than eighth grade | <input type="checkbox"/> I. Master's degree  |
| <input type="checkbox"/> D. Eighth grade           | <input type="checkbox"/> J. Medical degree   |
| <input type="checkbox"/> E. Some high school       | <input type="checkbox"/> K. Law degree       |
| <input type="checkbox"/> F. High-school graduate   | <input type="checkbox"/> L. Doctoral degree  |
|  | <input type="checkbox"/> M. Other _____      |

20. What is the main type of work your father does?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply  | <input type="checkbox"/> K. Business manager  |
| <input type="checkbox"/> B. Do not know   | <input type="checkbox"/> L. Health professional (for example: doctor, surgeon)                      |
| <input type="checkbox"/> C. Has primarily been unemployed                           | <input type="checkbox"/> M. Social services professional (for example: psychologist, social worker) |
| <input type="checkbox"/> D. Works in many different occupations                     | <input type="checkbox"/> N. Business executive  |
| <input type="checkbox"/> E. Unskilled worker (for example: factory worker, laborer) | <input type="checkbox"/> O. Not employed outside the home   |
| <input type="checkbox"/> F. Skilled worker (for example: welder, carpenter)         | <input type="checkbox"/> P. Military service  |
| <input type="checkbox"/> G. Clerical worker   | <input type="checkbox"/> Q. Other _____   |
| <input type="checkbox"/> H. Salesperson   |   |
| <input type="checkbox"/> I. Small business owner                                    |   |
| <input type="checkbox"/> J. Technical specialist (for example: computer programmer) |   |

21. Which of the following is true?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                     | <input type="checkbox"/> E. This is my father's second marriage            |
| <input type="checkbox"/> B. Do not know                        | <input type="checkbox"/> F. My father has been married more than two times |
| <input type="checkbox"/> C. My father is not presently married |  |
| <input type="checkbox"/> D. This is my father's first marriage |  |

22. How much education did your mother complete?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> G. Some college     |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> H. College graduate |
| <input type="checkbox"/> C. Less than eighth grade | <input type="checkbox"/> I. Master's degree  |
| <input type="checkbox"/> D. Eighth grade           | <input type="checkbox"/> J. Medical degree   |
| <input type="checkbox"/> E. Some high school       | <input type="checkbox"/> K. Law degree       |
| <input type="checkbox"/> F. High school graduate   | <input type="checkbox"/> L. Doctoral degree  |
|  | <input type="checkbox"/> M. Other _____      |

23. What is the main type of work your mother does?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply  | <input type="checkbox"/> K. Business manager              |
| <input type="checkbox"/> B. Do not know   | <input type="checkbox"/> L. Health professional           |
| <input type="checkbox"/> C. Has primarily been unemployed                           | (for example: doctor, surgeon)                            |
| <input type="checkbox"/> D. Works in many different occupations                     | <input type="checkbox"/> M. Social services professional  |
| <input type="checkbox"/> E. Unskilled worker (for example: factory worker, laborer) | (for example: psychologist, social worker)                |
| <input type="checkbox"/> F. Skilled worker (for example: welder, carpenter)         | <input type="checkbox"/> N. Business executive            |
| <input type="checkbox"/> G. Clerical worker   | <input type="checkbox"/> O. Not employed outside the home |
| <input type="checkbox"/> H. Salesperson   | <input type="checkbox"/> P. Military service              |
| <input type="checkbox"/> I. Small business owner                                    | <input type="checkbox"/> Q. Other _____                   |
| <input type="checkbox"/> J. Technical specialist (for example: computer programmer) |   |

24. Which of the following is true?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                     | <input type="checkbox"/> E. This is my mother's second marriage            |
| <input type="checkbox"/> B. Do not know                        |  |
| <input type="checkbox"/> C. My mother is not presently married | <input type="checkbox"/> F. My mother has been married more than two times |
| <input type="checkbox"/> D. This is my mother's first marriage |  |

25. What is the main source of income for your family?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply     | <input type="checkbox"/> F. Welfare                |
| <input type="checkbox"/> B. Do not know        | <input type="checkbox"/> G. Alimony                |
| <input type="checkbox"/> C. Father's job       | <input type="checkbox"/> H. Child support payments |
| <input type="checkbox"/> D. Mother's job       | <input type="checkbox"/> I. Other _____            |
| <input type="checkbox"/> E. Both parents' jobs |  |

26. How would you characterize your family?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> D. Lower class  |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> E. Middle class |
| <input type="checkbox"/> C. Poverty level  | <input type="checkbox"/> F. Upper class  |

### III. DEVELOPMENTAL HISTORY

27. How old was your father at the time of your birth?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> D. 30-39       |
| <input type="checkbox"/> B. 15-19       | <input type="checkbox"/> E. 40-49       |
| <input type="checkbox"/> C. 20-29       | <input type="checkbox"/> F. 50 or older |

28. How old was your mother at the time of your birth?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know | <input type="checkbox"/> D. 30-39       |
| <input type="checkbox"/> B. 15-19       | <input type="checkbox"/> E. 40-49       |
| <input type="checkbox"/> C. 20-29       | <input type="checkbox"/> F. 50 or older |

29. To your knowledge, what were the conditions of your birth (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know                 | <input type="checkbox"/> F. Mother ill at time of birth |
| <input type="checkbox"/> B. Normal, no unusual problems | <input type="checkbox"/> G. Breech birth                |
| <input type="checkbox"/> C. Premature birth             | <input type="checkbox"/> H. Caesarean delivery          |
| <input type="checkbox"/> D. Long labor                  | <input type="checkbox"/> I. Other _____                 |
| <input type="checkbox"/> E. Complications with delivery |   |

30. To your knowledge, what was your physical condition after birth (✓✓✓)?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Do not know                 | <input type="checkbox"/> I. Infection              |
| <input type="checkbox"/> B. Normal, no unusual problems | <input type="checkbox"/> J. Jaundice               |
| <input type="checkbox"/> C. Injured at birth            | <input type="checkbox"/> K. Fever                  |
| <input type="checkbox"/> D. Difficulty breathing        | <input type="checkbox"/> L. Had seizures           |
| <input type="checkbox"/> E. Problems with heart         | <input type="checkbox"/> M. Had blood transfusion  |
| <input type="checkbox"/> F. Problems with bones         | <input type="checkbox"/> N. Were in intensive care |
| <input type="checkbox"/> G. Problems with digestion     | <input type="checkbox"/> O. Placed in incubator    |
| <input type="checkbox"/> H. Low birth weight            | <input type="checkbox"/> P. Other _____            |

31. To your knowledge, how many days did you spend in the hospital after birth?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Do not know      | <input type="checkbox"/> D. More than 10 days |
| <input type="checkbox"/> B. 5 days or less   | <input type="checkbox"/> E. More than 20 days |
| <input type="checkbox"/> C. More than 5 days | <input type="checkbox"/> F. More than 30 days |

32. To your knowledge, when did you learn to walk?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know         | <input type="checkbox"/> C. Before 2nd birthday |
| <input type="checkbox"/> B. Before 1st birthday | <input type="checkbox"/> D. After 2nd birthday  |

33. To your knowledge, when did you learn to talk?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Do not know         | <input type="checkbox"/> C. Before 2nd birthday |
| <input type="checkbox"/> B. Before 1st birthday | <input type="checkbox"/> D. After 2nd birthday  |

34. Which of the following childhood illnesses or injuries did you have (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. None            | <input type="checkbox"/> K. Pneumonia           |
| <input type="checkbox"/> B. Do not remember | <input type="checkbox"/> L. Diabetes            |
| <input type="checkbox"/> C. Ear infections  | <input type="checkbox"/> M. Broken arm          |
| <input type="checkbox"/> D. Hernia          | <input type="checkbox"/> N. Broken leg          |
| <input type="checkbox"/> E. Measles         | <input type="checkbox"/> O. Serious head injury |
| <input type="checkbox"/> F. German measles  | <input type="checkbox"/> P. Allergies           |
| <input type="checkbox"/> G. Mumps           | <input type="checkbox"/> Q. Poisoning           |
| <input type="checkbox"/> H. Chicken pox     | <input type="checkbox"/> R. Seizures            |
| <input type="checkbox"/> I. Tonsillitis     | <input type="checkbox"/> S. Other _____         |
| <input type="checkbox"/> J. Asthma          |   |

35. Which of the following operations did you have as a child (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. None          | <input type="checkbox"/> D. Other _____ |
| <input type="checkbox"/> B. Appendectomy  |   |
| <input type="checkbox"/> C. Tonsillectomy |   |

36. Which of the following describes your experiences from ages 5-12?

- ☐ A. Had many close friends  
☐ B. Had several close friends  
☐ C. Had few close friends  
☐ D. Had no close friends

37. Which of the following describes your experiences from ages 5-12?

- ☐ A. Rarely got into trouble  
☐ B. Frequently got into trouble  
☐ C. Were always getting into trouble  
☐ D. Were considered a delinquent child

38. Which of the following describe your experiences from ages 5-12 (✓✓✓)?

- ☐ A. None  
☐ B. Parents did not get along  
☐ C. Parents got divorced  
☐ D. Parents got separated  
☐ E. Parents fought over custody  
☐ F. Parents fought over visitation  
☐ G. Family moved a lot  
☐ H. Family had financial problems  
☐ I. Did not get along with brothers and/or sisters  
☐ J. Had a lot of medical problems  
☐ K. Were physically abused  
☐ L. Were sexually abused  
☐ M. Other \_\_\_\_\_

39. How would you describe yourself as a child from ages 5-12 (✓✓✓)?

- ☐ A. Active  
☐ B. Passive  
☐ C. Happy  
☐ D. Content  
☐ E. Unhappy  
☐ F. Calm  
☐ G. Nervous  
☐ H. Fearful  
☐ I. Moody  
☐ J. Outgoing  
☐ K. Shy  
☐ L. Lonely  
☐ M. Quiet  
☐ N. Noisy  
☐ O. Coordinated  
☐ P. Clumsy  
☐ Q. Intelligent  
☐ R. Dull  
☐ S. Other \_\_\_\_\_

40. How would you describe your family relationships while you were a child from ages 5-12 (✓✓✓)?

- ☐ A. Does not apply  
☐ B. Marked by frequent arguments  
☐ C. Marked by physical fights  
☐ D. Unsupportive  
☐ E. Supportive  
☐ F. Warm, close  
☐ G. Cold, distant  
☐ H. Other \_\_\_\_\_

41. How would you describe your parents while you were a child from ages 5-12?

- ☐ A. Does not apply  
☐ B. Very strict  
☐ C. Strict  
☐ D. Average  
☐ E. Permissive  
☐ F. Very permissive

#### IV. EDUCATIONAL HISTORY

42. Which of the following did you attend (✓✓✓)?

- ☐ A. Infant day care  
☐ B. Preschool  
☐ C. Kindergarten

43. How old were you when you started first grade?

- ☐ A. 4  
☐ B. 5  
☐ C. 6  
☐ D. 7  
☐ E. Older than 7

44. What types of schools have you attended (✓✓✓)?

- ☐ A. Public school  
☐ B. Private school  
☐ C. Parochial school  
☐ D. School for the handicapped  
☐ E. Orphanage school  
☐ F. Military academy  
☐ G. Boarding school  
☐ H. Other \_\_\_\_\_

45. Did you have any problems when you first started school (✓✓✓)?

- ☐ A. No problems that you remember  
☐ B. Were afraid of school  
☐ C. Were sick a lot and missed a lot of school  
☐ D. Had to be punished to force you to go to school  
☐ E. Other \_\_\_\_\_

46. Which of the following describe your experiences in grades 1-8 (✓✓✓)?

- ☐ A. None  
☐ B. Had full-time special class for learning problems  
☐ C. Had part-time special class for learning problems  
☐ D. Had full-time special class for behavior problems  
☐ E. Had part-time special class for behavior problems  
☐ F. Had to repeat a grade  
☐ G. Had to repeat more than one grade  
☐ H. Had special tutoring  
☐ I. Other \_\_\_\_\_

47. Which of the following describes your experiences in grades 1-8?

- ☐ A. Generally received excellent grades  
☐ B. Generally received good grades  
☐ C. Generally received average grades  
☐ D. Generally received poor grades

48. Which of the following describes your experiences in grades 1-8?

- ☐ A. Enjoyed school  
☐ B. Felt neutral about school  
☐ C. Disliked school

49. Which of the following describes your experiences in grades 1-8?

- ☐ A. Got along well with all your teachers  
☐ B. Got along well with all but a few of your teachers  
☐ C. Usually got along poorly with your teachers

50. Which of the following describe your experiences in grades 1-8 (✓✓✓)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. None                                       | <input type="checkbox"/> E. Were suspended from school |
| <input type="checkbox"/> B. Frequently truant                          | <input type="checkbox"/> F. Were expelled from school  |
| <input type="checkbox"/> C. Frequently absent for health reasons       | <input type="checkbox"/> G. Other _____                |
| <input type="checkbox"/> D. Had to be disciplined in school frequently |  |
51. How old were you when you started the 9th grade?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Have not started 9th grade | <input type="checkbox"/> E. 13            |
| <input type="checkbox"/> B. Younger than 11            | <input type="checkbox"/> F. 14            |
| <input type="checkbox"/> C. 11                         | <input type="checkbox"/> G. 15            |
| <input type="checkbox"/> D. 12                         | <input type="checkbox"/> H. Older than 15 |
52. Did you have any problems when you first started the 9th grade (✓✓✓)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Have not started 9th grade                 | <input type="checkbox"/> E. Were afraid you would not do well academically |
| <input type="checkbox"/> B. No problems that you remember              | <input type="checkbox"/> F. Were afraid you would not fit in socially      |
| <input type="checkbox"/> C. Were anxious about starting school         | <input type="checkbox"/> G. Other _____                                    |
| <input type="checkbox"/> D. Were sick a lot and missed a lot of school |  |
53. Which of the following describes your experiences in high school?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Have not started high school | <input type="checkbox"/> D. Receive average grades |
| <input type="checkbox"/> B. Receive excellent grades     | <input type="checkbox"/> E. Receive poor grades    |
| <input type="checkbox"/> C. Receive good grades          |  |
54. Which of the following describe your experiences in high school (✓✓✓)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Have not started high school                     | <input type="checkbox"/> F. In part-time special class for behavior problems |
| <input type="checkbox"/> B. None   | <input type="checkbox"/> G. Had to repeat a grade                            |
| <input type="checkbox"/> C. In full-time special class for learning problems | <input type="checkbox"/> H. Had to repeat more than one grade                |
| <input type="checkbox"/> D. In part-time special class for learning problems | <input type="checkbox"/> I. Have had special tutoring                        |
| <input type="checkbox"/> E. In full-time special class for behavior problems | <input type="checkbox"/> J. Other _____                                      |
55. Which of the following describes your experiences in high school?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Have not started high school                       | <input type="checkbox"/> D. Usually get along poorly with your teachers |
| <input type="checkbox"/> B. Get along well with all your teachers              |   |
| <input type="checkbox"/> C. Get along well with all but a few of your teachers |   |

56. Which of the following describes your experiences in high school?
- |  |   |
|--|---|
| <input type="checkbox"/> A. Have not started high school | <input type="checkbox"/> C. Feel neutral about school |
| <input type="checkbox"/> B. Enjoy school                 | <input type="checkbox"/> D. Dislike school            |
57. Which of the following describe your experiences in high school (✓✓✓)?
- |   |  |
|---|--|
| <input type="checkbox"/> A. Have not started high school                | <input type="checkbox"/> F. Have been suspended            |
| <input type="checkbox"/> B. None  | <input type="checkbox"/> G. Have been expelled from school |
| <input type="checkbox"/> C. Frequently truant                           | <input type="checkbox"/> H. Other _____                    |
| <input type="checkbox"/> D. Frequently absent for health reasons        |  |
| <input type="checkbox"/> E. Have to be disciplined in school frequently |  |
58. In which activities do you participate while in school (✓✓✓)?
- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                         | <input type="checkbox"/> I. Academic clubs (math club, science club, etc.) |
| <input type="checkbox"/> B. None                                   | <input type="checkbox"/> J. Hobby clubs (chess club, stamp club, etc.)     |
| <input type="checkbox"/> C. Team sports (junior or senior varsity) | <input type="checkbox"/> K. Yearbook                                       |
| <input type="checkbox"/> D. Intramural sports                      | <input type="checkbox"/> L. Student newspaper                              |
| <input type="checkbox"/> E. Choir                                  | <input type="checkbox"/> M. Band   |
| <input type="checkbox"/> F. Glee club                              | <input type="checkbox"/> N. Other _____                                    |
| <input type="checkbox"/> G. Cheerleading                           |  |
| <input type="checkbox"/> H. Student government                     |  |
59. Describe your strengths in school subjects (✓✓✓).
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> H. Drama           |
| <input type="checkbox"/> B. None           | <input type="checkbox"/> I. Public Speaking |
| <input type="checkbox"/> C. English        | <input type="checkbox"/> J. Social Studies  |
| <input type="checkbox"/> D. Art            | <input type="checkbox"/> K. Science         |
| <input type="checkbox"/> E. Shop           | <input type="checkbox"/> L. History         |
| <input type="checkbox"/> F. Mathematics    | <input type="checkbox"/> M. Other _____     |
| <input type="checkbox"/> G. Language       |   |
60. Describe your weaknesses in school subjects (✓✓✓).
- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> H. Drama           |
| <input type="checkbox"/> B. None           | <input type="checkbox"/> I. Public Speaking |
| <input type="checkbox"/> C. English        | <input type="checkbox"/> J. Social Studies  |
| <input type="checkbox"/> D. Art            | <input type="checkbox"/> K. Science         |
| <input type="checkbox"/> E. Shop           | <input type="checkbox"/> L. History         |
| <input type="checkbox"/> F. Mathematics    | <input type="checkbox"/> M. Other _____     |
| <input type="checkbox"/> G. Language       |   |

61. Describe your skill strengths (✓✓✓).

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                   | <input type="checkbox"/> M. Understanding concepts         |
| <input type="checkbox"/> B. None                             | <input type="checkbox"/> N. Pleasing the teacher           |
| <input type="checkbox"/> C. Concentration                    | <input type="checkbox"/> O. Behaving correctly             |
| <input type="checkbox"/> D. Organization                     | <input type="checkbox"/> P. Taking tests                   |
| <input type="checkbox"/> E. Test preparation                 | <input type="checkbox"/> Q. Reading speed                  |
| <input type="checkbox"/> F. Papers and reports               | <input type="checkbox"/> R. Reading comprehension          |
| <input type="checkbox"/> G. Handwriting                      | <input type="checkbox"/> S. Spelling                       |
| <input type="checkbox"/> H. Memorizing                       | <input type="checkbox"/> T. Working hard and not giving up |
| <input type="checkbox"/> I. Paying attention in class        | <input type="checkbox"/> U. Intelligence                   |
| <input type="checkbox"/> J. Getting assignments done on time | <input type="checkbox"/> V. Other _____                    |
| <input type="checkbox"/> K. Being careful and checking work  |  |
| <input type="checkbox"/> L. Vocabulary and expression        |  |

62. Describe your skill weaknesses (✓✓✓).

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                   | <input type="checkbox"/> M. Understanding concepts         |
| <input type="checkbox"/> B. None                             | <input type="checkbox"/> N. Pleasing the teacher           |
| <input type="checkbox"/> C. Concentration                    | <input type="checkbox"/> O. Behaving correctly             |
| <input type="checkbox"/> D. Organization                     | <input type="checkbox"/> P. Taking tests                   |
| <input type="checkbox"/> E. Test preparation                 | <input type="checkbox"/> Q. Reading speed                  |
| <input type="checkbox"/> F. Papers and reports               | <input type="checkbox"/> R. Reading comprehension          |
| <input type="checkbox"/> G. Handwriting                      | <input type="checkbox"/> S. Spelling                       |
| <input type="checkbox"/> H. Memorizing                       | <input type="checkbox"/> T. Working hard and not giving up |
| <input type="checkbox"/> I. Paying attention in class        | <input type="checkbox"/> U. Intelligence                   |
| <input type="checkbox"/> J. Getting assignments done on time | <input type="checkbox"/> V. Other _____                    |
| <input type="checkbox"/> K. Being careful and checking work  |  |
| <input type="checkbox"/> L. Vocabulary and expression        |  |

63. What are your plans for high school?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Have already graduated              | <input type="checkbox"/> D. Not planning to return to school          |
| <input type="checkbox"/> B. Planning to graduate                | <input type="checkbox"/> E. Planning to return to school and graduate |
| <input type="checkbox"/> C. Planning to get equivalency diploma |   |

64. What are your plans for when you finish high school (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply, have already finished high school | <input type="checkbox"/> I. Plan to attend a vocational or technical school |
| <input type="checkbox"/> B. Does not apply, not in high school                | <input type="checkbox"/> J. Plan to attend a business school                |
| <input type="checkbox"/> C. Do not really have any plans                      | <input type="checkbox"/> K. Plan to attend a secretarial school             |
| <input type="checkbox"/> D. Plan to go to work                                | <input type="checkbox"/> L. Plan to get married                             |
| <input type="checkbox"/> E. Plan to live at home                              | <input type="checkbox"/> M. Plan to enter the armed services                |
| <input type="checkbox"/> F. Plan to live away from home                       | <input type="checkbox"/> N. Other _____                                     |
| <input type="checkbox"/> G. Plan to attend a four year college                |   |
| <input type="checkbox"/> H. Plan to attend a junior college                   |   |

## V. OCCUPATIONAL HISTORY

65. At what age did you begin working full-time?

- |   |                                |
|---|--------------------------------|
| <input type="checkbox"/> A. Have never worked full-time | <input type="checkbox"/> C. 15 |
| <input type="checkbox"/> B. Before age 15               | <input type="checkbox"/> D. 16 |
|   | <input type="checkbox"/> E. 17 |

66. At what age did you begin working part-time?

- |   |                                |
|---|--------------------------------|
| <input type="checkbox"/> A. Have never worked part-time | <input type="checkbox"/> C. 15 |
| <input type="checkbox"/> B. Before age 15               | <input type="checkbox"/> D. 16 |
|   | <input type="checkbox"/> E. 17 |

67. How many hours per week do you work?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. 15 to 19     |
| <input type="checkbox"/> B. Less than 5    | <input type="checkbox"/> F. 20 to 29     |
| <input type="checkbox"/> C. 5 to 9         | <input type="checkbox"/> G. 30 to 40     |
| <input type="checkbox"/> D. 10 to 14       | <input type="checkbox"/> H. More than 40 |

68. What type of job do you have?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply, not employed | <input type="checkbox"/> H. Work in family business |
| <input type="checkbox"/> B. Factory worker               | <input type="checkbox"/> I. Manager                 |
| <input type="checkbox"/> C. Child care worker            | <input type="checkbox"/> J. Restaurant worker       |
| <input type="checkbox"/> D. Baby sitter                  | <input type="checkbox"/> K. Janitor                 |
| <input type="checkbox"/> E. Laborer                      | <input type="checkbox"/> L. Maintenance             |
| <input type="checkbox"/> F. Clerk or secretary           | <input type="checkbox"/> M. Other _____             |
| <input type="checkbox"/> G. Salesperson                  |   |

69. How long have you been working in your current job?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply, not employed | <input type="checkbox"/> D. Less than 6 months |
| <input type="checkbox"/> B. Less than 1 month            | <input type="checkbox"/> E. Less than 9 months |
| <input type="checkbox"/> C. Less than 3 months           | <input type="checkbox"/> F. Less than 1 year   |
|  | <input type="checkbox"/> G. More than 1 year   |

70. What other types of work have you done (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply, have not worked | <input type="checkbox"/> H. Salesperson             |
| <input type="checkbox"/> B. None                            | <input type="checkbox"/> I. Work in family business |
| <input type="checkbox"/> C. Factory worker                  | <input type="checkbox"/> J. Manager                 |
| <input type="checkbox"/> D. Child care worker               | <input type="checkbox"/> K. Restaurant worker       |
| <input type="checkbox"/> E. Baby sitter                     | <input type="checkbox"/> L. Janitor                 |
| <input type="checkbox"/> F. Laborer                         | <input type="checkbox"/> M. Maintenance             |
| <input type="checkbox"/> G. Clerk or secretary              | <input type="checkbox"/> N. Other _____             |

71. What is the longest period of time you have been unemployed when you were looking for a job?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply     | <input type="checkbox"/> E. Less than 9 months |
| <input type="checkbox"/> B. Less than 1 month  | <input type="checkbox"/> F. Less than 1 year   |
| <input type="checkbox"/> C. Less than 3 months | <input type="checkbox"/> G. More than 1 year   |
| <input type="checkbox"/> D. Less than 6 months |  |

72. How many different full-time jobs have you had?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> F. 4           |
| <input type="checkbox"/> B. None           | <input type="checkbox"/> G. 5           |
| <input type="checkbox"/> C. 1              | <input type="checkbox"/> H. 6           |
| <input type="checkbox"/> D. 2              | <input type="checkbox"/> I. More than 6 |
| <input type="checkbox"/> E. 3              |   |

73. How many different part-time jobs have you had?

- ☐ A. Does not apply      ☐ F. 4  
☐ B. None      ☐ G. 5  
☐ C. 1      ☐ H. 6  
☐ D. 2      ☐ I. More than 6  
☐ E. 3

74. How many times have you been fired or laid off from a job?

- ☐ A. Does not apply      ☐ E. 3  
☐ B. None      ☐ F. 4  
☐ C. 1      ☐ G. 5  
☐ D. 2      ☐ H. More than 5

## VI. HEALTH, HABITS, AND BEHAVIOR

75. Which of the following are true (✓/✓/✓)?

- ☐ A. None      ☐ F. Currently being treated for hypertension (high blood pressure)  
☐ B. Currently taking medicine for Attention Deficit Disorder      ☐ G. Currently being treated for asthma  
☐ C. Currently taking medicine for a psychological or emotional problem      ☐ H. Currently being treated for allergies  
☐ D. Currently taking medicine for epilepsy (seizures)      ☐ I. Currently being treated for acne or skin problem  
☐ E. Currently being treated for heart problems      ☐ J. Other \_\_\_\_\_

76. Which of the following are true (✓/✓/✓)?

- ☐ A. None      ☐ E. In the past were treated for asthma  
☐ B. In the past took medicine for Attention Deficit Disorder      ☐ F. In the past were treated for allergies  
☐ C. In the past took medicine for a psychological or emotional problem      ☐ G. In the past were treated for acne or skin problem  
☐ D. In the past were treated for heart problems      ☐ H. Other \_\_\_\_\_

77. Do you currently have any physical problems that are not being treated by a medical doctor, but should be (✓/✓/✓)?

- ☐ A. No      ☐ F. Pain  
☐ B. Chest pain      ☐ G. Stomach problems  
☐ C. Difficulty with breathing      ☐ H. Vision problems  
☐ D. Dizziness      ☐ I. Other \_\_\_\_\_  
☐ E. Loss of consciousness

78. Has there been a recent change in your weight?

- ☐ A. No      ☐ E. Yes, a weight gain due to diet change  
☐ B. Yes, a weight gain      ☐ F. Yes, a weight loss due to dieting  
☐ C. Yes, a weight loss  
☐ D. Yes, a weight loss due to dieting

79. Has there been a recent change in your appetite?

- ☐ A. No      ☐ D. Yes, an increase in appetite  
☐ B. Yes, a loss of appetite  
☐ C. Yes, a decrease in appetite

80. Have you had recent problems with sleeping (✓/✓/✓)?

- ☐ A. No      ☐ F. Restlessness  
☐ B. Trouble getting to sleep      ☐ G. Wake up too early in the morning  
☐ C. Wake up a lot at night      ☐ H. Sleep enough, but don't feel rested  
☐ D. Do not get enough sleep      ☐ I. Other \_\_\_\_\_  
☐ E. Sleep too much

81. Which of the following is true?

- ☐ A. Have a steady boyfriend/girlfriend      ☐ D. Have had dates, but not dating currently  
☐ B. Date regularly      ☐ E. Have never dated  
☐ C. Date infrequently

82. How did you learn about sex (✓/✓/✓)?

- ☐ A. Prefer not to answer      ☐ F. In a sex education class  
☐ B. No source for learning about sex      ☐ G. Television  
☐ C. From your mother      ☐ H. Movies  
☐ D. From your father      ☐ I. Books  
☐ E. From your friends      ☐ J. Other \_\_\_\_\_

83. Which is true about your sex life?

- ☐ A. Prefer not to answer      ☐ D. Have no interest in sex  
☐ B. Have an active sex life      ☐ E. Are interested, but are abstaining from sex  
☐ C. Are interested in sex, but not active at this time

84. How many cigarettes a day do you smoke?

- ☐ A. None, have never smoked      ☐ D. One pack per day  
☐ B. None, but used to smoke      ☐ E. More than one pack per day  
☐ C. Less than one pack per day

85. How long have you been smoking (or did you smoke) cigarettes?

- ☐ A. Have never smoked      ☐ E. 3 years  
☐ B. Less than 1 year      ☐ F. 4 years  
☐ C. 1 year      ☐ G. More than 4 years  
☐ D. 2 years



96. Do you drink alcohol?  
☐ A. No ☐ C. Yes, regularly  
☐ B. Yes, occasionally ☐ D. Yes, daily
97. When do you drink (✓✓✓)?  
☐ A. Does not apply ☐ D. After school  
☐ B. Before school ☐ E. During work  
☐ C. During school hours ☐ F. On weekends
98. When did you start drinking?  
☐ A. Does not apply ☐ E. 3 years ago  
☐ B. Less than a year ago ☐ F. 4 years ago  
☐ C. 1 year ago ☐ G. Over 4 years ago  
☐ D. 2 years ago
99. When you drink, how many drinks do you usually have?  
☐ A. Does not apply ☐ D. 3  
☐ B. 1 ☐ E. 4  
☐ C. 2 ☐ F. 5 or more
90. Which of the following have you experienced because of drinking (✓✓✓)?  
☐ A. Does not apply ☐ H. Hallucinations (heard or saw things that were not there)  
☐ B. None ☐ I. Arguments with friends, parents, or relatives  
☐ C. Problems with performance in school ☐ J. Other \_\_\_\_\_  
☐ D. Problems with performance at work  
☐ E. Tremors or shakes  
☐ F. Blackouts  
☐ G. Problems with memory
91. Do you use any illegal drugs?  
☐ A. No ☐ C. Occasionally  
☐ B. No, but did in the past ☐ D. Regularly  
☐ E. Daily
92. Which drugs do you, or did you, use (✓✓✓)?  
☐ A. Does not apply ☐ I. Barbiturates ("downers")  
☐ B. Heroin ☐ J. Glue  
☐ C. Cocaine ☐ K. Paint thinner  
☐ D. LSD ☐ L. Gasoline  
☐ E. PCP ☐ M. Prescription drugs  
☐ F. Marijuana ☐ N. Tranquilizers  
☐ G. Hashish ☐ O. Diet pills  
☐ H. Amphetamines ("uppers") ☐ P. Other \_\_\_\_\_
93. How long have you been using, or did you use, illegal drugs?  
☐ A. Does not apply ☐ E. 1 year  
☐ B. Less than 3 months ☐ F. 2 years  
☐ C. Less than 6 months ☐ G. 3 years  
☐ D. Less than 1 year ☐ H. Over 3 years

94. What contact have you had with legal authorities (✓✓✓)?  
☐ A. None ☐ H. Juvenile detention once  
☐ B. Warned by police once ☐ I. Juvenile detention more than once  
☐ C. Warned by police more than once ☐ J. Traffic violation once  
☐ D. Arrested once ☐ K. Traffic violation more than once  
☐ E. Arrested more than once ☐ L. Other \_\_\_\_\_  
☐ F. Jailed once  
☐ G. Jailed more than once
95. Are any of the following true (✓✓✓)?  
☐ A. No ☐ E. On parole  
☐ B. Facing felony charge ☐ F. On probation  
☐ C. Facing misdemeanor charge ☐ G. Have been declared delinquent  
☐ D. Have been declared ungovernable ☐ H. Other \_\_\_\_\_

96. Have you had contact with the police for any of the following (✓✓✓)?  
☐ A. No ☐ K. Forgery  
☐ B. Curfew violation ☐ L. Breaking and entering  
☐ C. Drinking while under age ☐ M. Destruction of property  
☐ D. Truancy ☐ N. Physically threatening others  
☐ E. Speeding ☐ O. Assault  
☐ F. Reckless driving ☐ P. Assault with a weapon  
☐ G. Drug use ☐ Q. Other \_\_\_\_\_  
☐ H. Drug sales  
☐ I. Auto theft  
☐ J. Robbery

## VII. FAMILY HISTORY

97. Which of the following is true about your natural mother?  
☐ A. Does not apply ☐ D. She is alive but in poor health  
☐ B. Do not know if she is alive or deceased ☐ E. She is deceased  
☐ C. She is alive and well
98. Which of the following medical problems has your mother had (✓✓✓)?  
☐ A. Does not apply ☐ J. Low back pain  
☐ B. Do not know ☐ K. Problems with lungs or breathing  
☐ C. None ☐ L. Problems with digestive system  
☐ D. Arthritis ☐ M. Other \_\_\_\_\_  
☐ E. Cancer  
☐ F. Diabetes  
☐ G. Epilepsy (seizures)  
☐ H. Heart problems  
☐ I. Hypertension (high blood pressure)
99. Which of the following is true about your natural father?  
☐ A. Does not apply ☐ D. He is alive but in poor health  
☐ B. Do not know if he is alive or deceased ☐ E. He is deceased  
☐ C. He is alive and well

100. Which of the following medical problems has your father had (✓✓✓)?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                     | <input type="checkbox"/> J. Low back pain                    |
| <input type="checkbox"/> B. Do not know                        | <input type="checkbox"/> K. Problems with lungs or breathing |
| <input type="checkbox"/> C. None                               | <input type="checkbox"/> L. Problems with digestive system   |
| <input type="checkbox"/> D. Arthritis                          | <input type="checkbox"/> M. Other _____                      |
| <input type="checkbox"/> E. Cancer                             |  |
| <input type="checkbox"/> F. Diabetes                           |  |
| <input type="checkbox"/> G. Epilepsy (seizures)                |  |
| <input type="checkbox"/> H. Heart problems                     |  |
| <input type="checkbox"/> I. Hypertension (high blood pressure) |  |

101. Which of the following medical problems have any of your brothers or sisters had (✓✓✓)?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                     | <input type="checkbox"/> J. Low back pain                    |
| <input type="checkbox"/> B. Do not know                        | <input type="checkbox"/> K. Problems with lungs or breathing |
| <input type="checkbox"/> C. None                               | <input type="checkbox"/> L. Problems with digestive system   |
| <input type="checkbox"/> D. Arthritis                          | <input type="checkbox"/> M. Other _____                      |
| <input type="checkbox"/> E. Cancer                             |  |
| <input type="checkbox"/> F. Diabetes                           |  |
| <input type="checkbox"/> G. Epilepsy (seizures)                |  |
| <input type="checkbox"/> H. Heart problems                     |  |
| <input type="checkbox"/> I. Hypertension (high blood pressure) |  |

102. Which of the following have been treated for psychological problems (either as an inpatient or outpatient), other than alcohol or drug abuse (✓✓✓)?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Father  |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Sister  |
| <input type="checkbox"/> C. None           | <input type="checkbox"/> G. Brother |
| <input type="checkbox"/> D. Mother         |                                     |

103. Which of the following have had problems with alcohol (✓✓✓)?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Father  |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Sister  |
| <input type="checkbox"/> C. None           | <input type="checkbox"/> G. Brother |
| <input type="checkbox"/> D. Mother         |                                     |

104. Which of the following have had problems with drugs (✓✓✓)?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Father  |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Sister  |
| <input type="checkbox"/> C. None           | <input type="checkbox"/> G. Brother |
| <input type="checkbox"/> D. Mother         |                                     |

105. Which of the following have had learning problems in school (✓✓✓)?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> E. Father  |
| <input type="checkbox"/> B. Do not know    | <input type="checkbox"/> F. Sister  |
| <input type="checkbox"/> C. None           | <input type="checkbox"/> G. Brother |
| <input type="checkbox"/> D. Mother         |                                     |

## VIII. CURRENT SITUATION

106. Describe your responsibilities at home (✓✓✓).

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply           | <input type="checkbox"/> H. Helping to clean up after meals |
| <input type="checkbox"/> B. None                     | <input type="checkbox"/> I. Housework                       |
| <input type="checkbox"/> C. Yard work                | <input type="checkbox"/> J. Cleaning up your room           |
| <input type="checkbox"/> D. Baby sitting             | <input type="checkbox"/> K. Other _____                     |
| <input type="checkbox"/> E. Taking out garbage       |   |
| <input type="checkbox"/> F. Doing laundry            |   |
| <input type="checkbox"/> G. Helping to prepare meals |   |

107. Describe your privileges at home (✓✓✓).

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply                             | <input type="checkbox"/> I. Choosing your own hair style           |
| <input type="checkbox"/> B. None                                       | <input type="checkbox"/> J. Deciding how to spend your money       |
| <input type="checkbox"/> C. Driving the car during the day by yourself | <input type="checkbox"/> K. Spending the night at a friend's house |
| <input type="checkbox"/> D. Driving the car at night by yourself       | <input type="checkbox"/> L. Going to unchaperoned parties          |
| <input type="checkbox"/> E. Using the telephone whenever you want      | <input type="checkbox"/> M. Going only to chaperoned parties       |
| <input type="checkbox"/> F. Setting your own curfew                    | <input type="checkbox"/> N. Going to concerts with friends         |
| <input type="checkbox"/> G. Staying home alone when parents are away   | <input type="checkbox"/> O. Other _____                            |
| <input type="checkbox"/> H. Buying your own clothes                    |  |

108. Do you receive an allowance?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply             | <input type="checkbox"/> D. Yes, even if you do not do chores |
| <input type="checkbox"/> B. No                         | <input type="checkbox"/> E. Yes, if you ask for it            |
| <input type="checkbox"/> C. Yes, only if you do chores | <input type="checkbox"/> F. Other _____                       |

109. What things do you and your parents argue about (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. Does not apply        | <input type="checkbox"/> N. Smoking                 |
| <input type="checkbox"/> B. None                  | <input type="checkbox"/> O. Music                   |
| <input type="checkbox"/> C. Telephone             | <input type="checkbox"/> P. Clothes                 |
| <input type="checkbox"/> D. Privacy               | <input type="checkbox"/> Q. Sex                     |
| <input type="checkbox"/> E. Alcohol               | <input type="checkbox"/> R. School                  |
| <input type="checkbox"/> F. Drugs                 | <input type="checkbox"/> S. Bedtime                 |
| <input type="checkbox"/> G. Driving               | <input type="checkbox"/> T. Dating                  |
| <input type="checkbox"/> H. Friends               | <input type="checkbox"/> U. Curfew                  |
| <input type="checkbox"/> I. Homework              | <input type="checkbox"/> V. Spending money          |
| <input type="checkbox"/> J. Etiquette and manners | <input type="checkbox"/> W. Cleanliness and hygiene |
| <input type="checkbox"/> K. Chores                | <input type="checkbox"/> X. Other _____             |
| <input type="checkbox"/> L. Bad language          |   |
| <input type="checkbox"/> M. Lying                 |   |

110. What kinds of discipline do your parents use (✓✓✓)?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply      | <input type="checkbox"/> F. Withdrawal of privileges |
| <input type="checkbox"/> B. None                | <input type="checkbox"/> G. Grounding                |
| <input type="checkbox"/> C. Physical punishment | <input type="checkbox"/> H. Loss of allowance        |
| <input type="checkbox"/> D. Yelling             | <input type="checkbox"/> I. Other _____              |
| <input type="checkbox"/> E. Lectures            |  |

111. How strict are your parents?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply | <input type="checkbox"/> D. Average         |
| <input type="checkbox"/> B. Very strict    | <input type="checkbox"/> E. Permissive      |
| <input type="checkbox"/> C. Strict         | <input type="checkbox"/> F. Very permissive |

112. What kinds of problems do your parents have (✓✓✓)?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply              | <input type="checkbox"/> G. Financial problems             |
| <input type="checkbox"/> B. None                        | <input type="checkbox"/> H. Job problems                   |
| <input type="checkbox"/> C. Problems with health        | <input type="checkbox"/> I. Problems from breaking the law |
| <input type="checkbox"/> D. Marriage problems           | <input type="checkbox"/> J. Emotional problems             |
| <input type="checkbox"/> E. Problems with alcohol abuse | <input type="checkbox"/> K. Other _____                    |
| <input type="checkbox"/> F. Problems with drug abuse    |  |

113. How would you describe your relationship with your parents?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply             | <input type="checkbox"/> E. Negative      |
| <input type="checkbox"/> B. Very positive              | <input type="checkbox"/> F. Very negative |
| <input type="checkbox"/> C. Positive                   |   |
| <input type="checkbox"/> D. Both positive and negative |   |

114. How would you describe your relationships with your brother(s) and/or sister(s)?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply             | <input type="checkbox"/> E. Negative      |
| <input type="checkbox"/> B. Very positive              | <input type="checkbox"/> F. Very negative |
| <input type="checkbox"/> C. Positive                   |   |
| <input type="checkbox"/> D. Both positive and negative |   |

115. How would you describe your family's relationships now (✓✓✓)?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply               | <input type="checkbox"/> E. Supportive    |
| <input type="checkbox"/> B. Marked by frequent arguments | <input type="checkbox"/> F. Warm, close   |
| <input type="checkbox"/> C. Marked by physical fights    | <input type="checkbox"/> G. Cold, distant |
| <input type="checkbox"/> D. Unsupportive                 | <input type="checkbox"/> H. Other _____   |

116. How important do you think you are in your family?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply     | <input type="checkbox"/> D. Somewhat unimportant |
| <input type="checkbox"/> B. Important          |  |
| <input type="checkbox"/> C. Somewhat important | <input type="checkbox"/> E. Unimportant          |

117. Have you ever been abused by one or both of your parents (✓✓✓)?

- |   |  |
|---|--|
| <input type="checkbox"/> A. Does not apply          | <input type="checkbox"/> E. Yes, verbally abused |
| <input type="checkbox"/> B. No                      | <input type="checkbox"/> F. Yes, sexually abused |
| <input type="checkbox"/> C. Yes, physically abused  | <input type="checkbox"/> G. Yes, neglected       |
| <input type="checkbox"/> D. Yes, emotionally abused |  |

118. When do you plan to move out of your parents' household?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Does not apply         | <input type="checkbox"/> D. Before age 18   |
| <input type="checkbox"/> B. Do not know            | <input type="checkbox"/> E. Before age 21   |
| <input type="checkbox"/> C. Have already moved out | <input type="checkbox"/> F. Age 21 or after |

119. Which of the following describes you now?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Have many close friends    | <input type="checkbox"/> C. Have few close friends |
| <input type="checkbox"/> B. Have several close friends | <input type="checkbox"/> D. Have no close friends  |

120. How would you describe your friends (✓✓✓)?

- |  |  |
|--|--|
| <input type="checkbox"/> A. Does not apply           | <input type="checkbox"/> K. Some have legal problems                       |
| <input type="checkbox"/> B. Excellent students       | <input type="checkbox"/> L. None have legal problems                       |
| <input type="checkbox"/> C. Good students            | <input type="checkbox"/> M. Pressure you to do things you shouldn't        |
| <input type="checkbox"/> D. Poor students            | <input type="checkbox"/> N. Do not pressure you to do things you shouldn't |
| <input type="checkbox"/> E. Have jobs                | <input type="checkbox"/> O. Other _____                                    |
| <input type="checkbox"/> F. Do not have jobs         |  |
| <input type="checkbox"/> G. Use alcohol              |  |
| <input type="checkbox"/> H. Do not use alcohol       |  |
| <input type="checkbox"/> I. Use illegal drugs        |  |
| <input type="checkbox"/> J. Do not use illegal drugs |  |

121. What do you do for fun (✓✓✓)?

- |  |   |
|--|---|
| <input type="checkbox"/> A. Nothing                  | <input type="checkbox"/> I. Play video games    |
| <input type="checkbox"/> B. Listen to music          | <input type="checkbox"/> J. Play computer games |
| <input type="checkbox"/> C. Read                     | <input type="checkbox"/> K. Work on a computer  |
| <input type="checkbox"/> D. Talk on the phone        | <input type="checkbox"/> L. Church activities   |
| <input type="checkbox"/> E. Play organized sports    | <input type="checkbox"/> M. Dating              |
| <input type="checkbox"/> F. Play neighborhood sports | <input type="checkbox"/> N. Dancing             |
| <input type="checkbox"/> G. Go to parties            | <input type="checkbox"/> O. Work on hobbies     |
| <input type="checkbox"/> H. Go to concerts           | <input type="checkbox"/> P. Other _____         |

122. Which of the following have you experienced in the past year (✓✓✓)?

- |   |   |
|---|---|
| <input type="checkbox"/> A. None  | <input type="checkbox"/> G. Parent being seriously ill or injured |
| <input type="checkbox"/> B. Getting pregnant/ girlfriend getting pregnant | <input type="checkbox"/> H. Death of a parent                     |
| <input type="checkbox"/> C. Birth of child/ girlfriend having a child     | <input type="checkbox"/> I. Loss of job                           |
| <input type="checkbox"/> D. Serious illness or injury                     | <input type="checkbox"/> J. Change of schools                     |
| <input type="checkbox"/> E. Parents' separation                           | <input type="checkbox"/> K. Dropping out of school                |
| <input type="checkbox"/> F. Parents' divorce                              | <input type="checkbox"/> L. School problems                       |
|   | <input type="checkbox"/> M. Other _____                           |

123. How would you describe yourself now (✓✓✓)?

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> A. Active   | <input type="checkbox"/> K. Shy         |
| <input type="checkbox"/> B. Passive  | <input type="checkbox"/> L. Lonely      |
| <input type="checkbox"/> C. Happy    | <input type="checkbox"/> M. Quiet       |
| <input type="checkbox"/> D. Content  | <input type="checkbox"/> N. Noisy       |
| <input type="checkbox"/> E. Unhappy  | <input type="checkbox"/> O. Coordinated |
| <input type="checkbox"/> F. Calm     | <input type="checkbox"/> P. Clumsy      |
| <input type="checkbox"/> G. Nervous  | <input type="checkbox"/> Q. Intelligent |
| <input type="checkbox"/> H. Fearful  | <input type="checkbox"/> R. Dull        |
| <input type="checkbox"/> I. Moody    | <input type="checkbox"/> S. Other _____ |
| <input type="checkbox"/> J. Outgoing |   |