

Welcome to the Bert Nash Center! *Our goal* is to help you reach *your goals* in the most efficient and effective way. That's why we've developed this questionnaire in addition to asking you to fill out the Child Behavior Checklist forms before your first session.

This questionnaire should be completed by parents of children twelve and under, and by teenagers themselves. If there are questions you are uncomfortable answering, wait and discuss them with your therapist. Upon completion, please give this questionnaire to the receptionist. The information will become part of your confidential record.

Client Name: _____ Date: _____

Who is filling out this questionnaire? _____

1. Please state in your own words why you are coming to the Bert Nash Center at this time:

2. How long have you had these concerns?

3. How do you hope to benefit from our services?

4. Health Status Review

When was the last time the client had a physical exam? _____

Does the client use alcohol or other drugs?

Alcohol - Yes No Other drugs - Yes No

In the first column of boxes, please check any of the following the client may have currently; in the second column, please check any the client may have had in the past.

Current		In the Past				Current		In the Past	
<input type="checkbox"/>	<input type="checkbox"/>	- No Handicap 00	<input type="checkbox"/>	<input type="checkbox"/>	- Parkinson's Disease 21	<input type="checkbox"/>	<input type="checkbox"/>	- Eating Disorder 40	
<input type="checkbox"/>	<input type="checkbox"/>	- Organic Problem in Communication 02	<input type="checkbox"/>	<input type="checkbox"/>	- Tuberculosis 22	<input type="checkbox"/>	<input type="checkbox"/>	- Overweight 41	
<input type="checkbox"/>	<input type="checkbox"/>	- Severe Visual Impairment 03	<input type="checkbox"/>	<input type="checkbox"/>	- Cirrhosis 23	<input type="checkbox"/>	<input type="checkbox"/>	- Underweight 42	
<input type="checkbox"/>	<input type="checkbox"/>	- Severe Hearing Loss 04	<input type="checkbox"/>	<input type="checkbox"/>	- Alzheimer's Disease 24	<input type="checkbox"/>	<input type="checkbox"/>	- Sleep Disorder 43	
<input type="checkbox"/>	<input type="checkbox"/>	- Difficulties in Ambulation 05	<input type="checkbox"/>	<input type="checkbox"/>	- Korsakoff's Syndrome 25	<input type="checkbox"/>	<input type="checkbox"/>	- Menopause 44	
<input type="checkbox"/>	<input type="checkbox"/>	- Developmental Disability 07	<input type="checkbox"/>	<input type="checkbox"/>	- Seizure Disorder 26	<input type="checkbox"/>	<input type="checkbox"/>	- Urinary Tract Infection 45	
<input type="checkbox"/>	<input type="checkbox"/>	- Fibromyalgia 08	<input type="checkbox"/>	<input type="checkbox"/>	- Stroke 27	<input type="checkbox"/>	<input type="checkbox"/>	- Crohn's Disease 46	
<input type="checkbox"/>	<input type="checkbox"/>	- Mental Retardation 09	<input type="checkbox"/>	<input type="checkbox"/>	- Blood Clots 28	<input type="checkbox"/>	<input type="checkbox"/>	- Other 47	
<input type="checkbox"/>	<input type="checkbox"/>	- Diabetes 10	<input type="checkbox"/>	<input type="checkbox"/>	- Leukemia 29	if other, describe: _____			
<input type="checkbox"/>	<input type="checkbox"/>	- High Blood Pressure 11	<input type="checkbox"/>	<input type="checkbox"/>	- Arthritis 30	_____			
<input type="checkbox"/>	<input type="checkbox"/>	- Immune System Suppression 12	<input type="checkbox"/>	<input type="checkbox"/>	- Ulcers 31	_____			
<input type="checkbox"/>	<input type="checkbox"/>	- Chronic Pain 13	<input type="checkbox"/>	<input type="checkbox"/>	- Asthma 32	_____			
<input type="checkbox"/>	<input type="checkbox"/>	- Hepatitis 14	<input type="checkbox"/>	<input type="checkbox"/>	- Allergies 33				
<input type="checkbox"/>	<input type="checkbox"/>	- Multiple Sclerosis 15	<input type="checkbox"/>	<input type="checkbox"/>	- Pregnancy 34				
<input type="checkbox"/>	<input type="checkbox"/>	- Heart Problems 16	<input type="checkbox"/>	<input type="checkbox"/>	- Head Injury 35				
<input type="checkbox"/>	<input type="checkbox"/>	- Thyroid Problems 17	<input type="checkbox"/>	<input type="checkbox"/>	- Irritable Bowel Syndrome 36				
<input type="checkbox"/>	<input type="checkbox"/>	- Emphysema 18	<input type="checkbox"/>	<input type="checkbox"/>	- Constipation 37				
<input type="checkbox"/>	<input type="checkbox"/>	- Cancer 19	<input type="checkbox"/>	<input type="checkbox"/>	- Diarrhea 38				
<input type="checkbox"/>	<input type="checkbox"/>	- Polio 20	<input type="checkbox"/>	<input type="checkbox"/>	- Anemia 39				

Does the client smoke/chew tobacco? No Yes
 When did he/she stop? _____

If yes, how many years? _____
 How many cigarettes per day? _____

Reg. ID# _____ Client Name: _____

Check all conditions any family members (grandparents, parents, or siblings) have had.

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia/ bleeding problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/ seizures | <input type="checkbox"/> Bipolar | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver/ kidney | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> History of abuse | <input type="checkbox"/> Heart disease/ angina | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Others _____ | |

5. Has the client had problems sleeping? (check all that apply)

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Sleep too much | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Can't fall asleep |
| <input type="checkbox"/> Night terror | <input type="checkbox"/> Can't wake up | <input type="checkbox"/> Sleepwalk | <input type="checkbox"/> Sleeps too little |
| <input type="checkbox"/> Wakes during the night | | | |

6. Overall, would you say the client's general level of functioning (at home, at school, emotionally and mentally) now, compared with one year ago is:

- Much better now Somewhat better Same Somewhat worse Much worse

7. Has the client had problems concerning appetite or eating? (check all that apply)

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Lost weight recently | <input type="checkbox"/> Gained weight | <input type="checkbox"/> Can't eat |
| <input type="checkbox"/> Eats very little | <input type="checkbox"/> Purges | | |

8. Has the client had legal involvement? Yes No If yes, describe: _____

9. Has client used alcohol or other drugs? Alcohol: Yes No Other Drugs: Yes No

If Yes,

- | | |
|--|--|
| • Has client ever felt he/she ought to cut down on amount of drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have people ever annoyed the client by criticizing the client's drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Has the client ever felt bad or guilty about his/her drinking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Has the client ever had a drink first thing in the morning to steady his/her nerves or to get rid of a hang over (eye opener)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

10. School Information

a. Number of days of in-school suspension in the last 90 days? _____

b. Does the client get support in school from a paraprofessional or individual attendant care? Yes No

DO NOT WRITE BELOW THIS LINE

CBC Scores

Total competence: _____

Total problem: _____

Date administered: _____

Internalizing: _____

Externalizing: _____

Reg. ID# _____ Client Name: _____