MERIDELL ACHIEVEMENT CENTER
Patient and Family Questionnaire

(Place name label here)

PATIENT LEGAL NAME: _____ **DATE OF BIRTH:** _____ **GENDER:** ☐**M** ☐**F**

1. FAMILY OF ORIGIN AND CURRENT CARETAKERS (check all that apply):

☐Biological parents ☐Mother ☐Father Name(s): _____
☐Adoptive parents ☐Mother ☐Father Name(s): _____
☐Step-parents ☐Mother ☐Father Name(s): _____
☐Deceased parents ☐Mother ☐Father Name(s): _____
☐Other _____ ☐_____ ☐_____ Name(s): _____
If not biological parent, how, and at what age did patient come into your care: _____
☐Non-custodial ☐Mother ☐Father Name: _____
☐No rights ☐Mother ☐Father Name: _____
☐N/A ☐Custody of child with (legal guardian) Name: _____
☐N/A ☐Custody dispute in progress, current status: _____
☐N/A Describe custody arrangements (if applicable): _____
☐Divides time between households. Describe: _____

2. CURRENT HOUSEHOLD MEMBERS LIVING WITH PATIENT (parents, siblings, relatives and friends):

Relationship to Patient	Name	Age	Describe Relationship with Household Member

3. SIGNIFICANT FAMILY MEMBERS / RELATIVES / OTHERS NOT IN SAME HOUSEHOLD: ☐ **N/A**

Relationship to Patient	Name	Age	Describe Relationship with Other

4. FAMILY HISTORY OF MENTAL HEALTH ISSUES:

	☐Bio Maternal History Unknown Mother's Side Relationship to Patient	☐Bio Paternal History Unknown Father's Side Relationship to Patient
Psychiatric		
Neurological		
History of Suicide		
Substance Abuse		
Learning Disabilities		
Aggression		
Legal Issues		
Other		

5. SOCIAL HISTORY:

Patient is able to create friendships. ☐Never ☐Rarely ☐Sometimes ☐Always
Patient is able to maintain friendships. ☐Never ☐Rarely ☐Sometimes ☐Always
Patient is able to relate to peers in a respectful manner. ☐Never ☐Rarely ☐Sometimes ☐Always
Patient is able to relate to adults in a respectful manner. ☐Never ☐Rarely ☐Sometimes ☐Always

PATIENT NAME: _____

(Place name label here)

6. DEVELOPMENTAL HISTORY:

Prenatal: ☐Normal or unremarkable ☐No information available ☐Problems with (eg, complications during pregnancy/delivery, substance use, etc.): _____

Developmental Milestones: ☐Normal Limits ☐Delayed ☐No information available

Walking:	☐Early: _____	☐12-months	☐Later: _____
Talking in 3-word sentences:	☐Early: _____	☐24-months	☐Later: _____
Toilet Training:	☐Early: _____	☐36-months	☐Later: _____

Birth to 1-year: ☐Normal or unremarkable; ☐No information available; ☐Problems with: _____

_____

2 to 5 years: ☐Normal or unremarkable; ☐No information available; ☐Problems with: _____

_____

6 to 12 years: ☐Normal or unremarkable; ☐No information available; ☐Problems with: _____

_____

13 to 18 years: ☐Normal or unremarkable; ☐No information available; ☐Problems with: _____

_____

The patient currently functions: ☐At age level ☐Above age level ☐Below age level

Handedness: ☐Right ☐Left

Significant / relevant issues from childhood impacting current illness (ex, recent, frequent moves, change in schools, abuse, trauma, medical issues, loss of parent, divorce, abandonment, etc):_____

_____

_____

7. EDUCATION:

Current grade level: _____ History of repeating a grade: ☐No ☐Yes which grade(s):_____

Current grades: _____☐Improving ☐Declining

Learning barriers: ☐Reading & writing difficulties ☐Speech impediments ☐Impaired vision ☐Fatigue

☐Other, description of symptoms and age when began: _____

☐Patient is currently enrolled in school. School name: _____

☐Patient is currently home schooled. Reason: _____

☐Not enrolled or attending school due to: ☐Dropped out ☐Refuses to attend ☐Other_____

☐No ☐Yes School behavioral problems? Details (ex. age of onset, specific behaviors, consequences): _____

_____

☐No ☐Yes Patient has a history of requiring 1:1 educational aide for behavioral management?

☐No ☐Yes Patient has a 504 plan for: ☐Medical _____ ☐Behavioral _____ ☐Other _____

☐No ☐Yes Special Educational Services: What is their qualifying diagnosis? _____

Details (ex, accommodations, age when services began, services received): _____

***Please provide most recent copies of educational plans at the time of admission.**

8. ELOPEMENT: ☐**NO HISTORY OF RUNNING AWAY**

☐No ☐Yes Threatens to run away? ☐No ☐Yes Interventions have prevented elopement?

☐No ☐Yes Patient has run away from home? When did patient last run? _____

If yes, frequency: _____Is it planned? _____How long was patient gone? _____

Where does patient go?_____

PATIENT NAME: _____

(Place name label here)

9. HISTORY OF SELF HARM/SUICIDAL IDEATIONS / ATTEMPTS: ☐**NO HISTORY OF SUICIDAL IDEATIONS**

History of self-harming behaviors? Describe: ☐Banging head ☐Scratching ☐Biting ☐Hitting
☐Pulling out or shaving hair, eyelashes or eyebrows ☐Self-tattooing ☐Cutting ☐Burning ☐Self-Piercing
☐Other: _____

Patient's mood during suicidal ideations? ☐Angry ☐Sad ☐Depressed ☐Manipulative ☐Other _____

☐No ☐Yes Patient has verbalized suicidal ideations? When: _____

☐No ☐Yes Patient has verbalized plan? Describe: _____

☐No ☐Yes Suicidal gesture could / would have resulted in patient's death without interventions?

Describe any attempts:

Date	Age	Method	Injury	Treatment / Outcome

Does patient has access to: A gun or other weapons? ☐No ☐Yes **IF YES:** ☐ within home ☐ outside of home?
Other weapons in the home associated with hobbies or collections? ☐No ☐Yes
Other potentially dangerous items in the home (eg, medications)? ☐No ☐Yes

How are weapons and/or other potentially dangerous items in the home secured, or how will they be secured in the future?

_____

10. HISTORY OF VIOLENT / AGGRESSIVE / ANTISOCIAL BEHAVIORS:

☐No ☐Yes Patient has a history of violent or aggressive behaviors
☐No ☐Yes Aggressive behaviors have been directed towards: ☐Parents ☐Siblings ☐Peers ☐School staff
☐No ☐Yes Aggressive behaviors are escalating and/or are more frequent
☐No ☐Yes Patient plans aggressive acts
☐No ☐Yes Patient is very careful to protect self when aggressive
☐No ☐Yes Patient can control behavior when aggressive
☐No ☐Yes Patient hides or attempts to hide aggressive acts
☐No ☐Yes Patient steals from: ☐Family ☐Friends ☐School ☐Stores ☐Neighbors ☐Others_____
☐No ☐Yes Patient has history of delusions or command hallucinations prompting them to be aggressive
☐No ☐Yes Patient experiences rapid mood swings
☐No ☐Yes Patient experiences paranoid ideation
☐No ☐Yes Physical aggression appears to be without gain or purpose
☐No ☐Yes Patient aggression is unplanned, out of the blue
☐No ☐Yes Patient is completely out of control when aggressive
☐No ☐Yes Patient exposes self to physical harm when aggressive
☐No ☐Yes Patient destroys own property without apparent profit or gain
☐No ☐Yes Patient vandalizes or destroys others property or belongings?
☐No ☐Yes Patient has been physically aggressive with a weapon? Describe (eg, patient age, victim, weapon used, extent of injury to victim): _____
☐No ☐Yes Patient has been physically aggressive and/or cruel to animals? Describe: _____

_____

What are the precipitating events that typically trigger aggressive behaviors? _____

Types of physical aggression towards others:

☐Pushing ☐Head Butting ☐Scratching ☐Stabbing ☐Smothering ☐Throwing items at others
☐Punching ☐Biting ☐Pushing Down ☐Choking ☐Kicking ☐_____ ☐_____

11. LEGAL HISTORY: ☐**NO LEGAL ISSUES**

☐No ☐Yes Patient has been arrested? Describe (eg, patient age, offense, outcome): _____

_____

☐No ☐Yes Patient is currently on probation/parole? Name and county of Probation Officer: _____

_____

☐No ☐Yes Patient has charges pending? Describe (eg, patient age, offense, court date): _____

_____

PATIENT NAME: _____

(Place name label here)

12. PATIENT HISTORY OF ALCOHOL AND DRUG USE: ☐**NO HISTORY OF USE**

☐Suspected, unconfirmed ☐Experimentation ☐Becoming problematic ☐Big problem

Generally uses ☐Alone ☐With others How does the patient procure or pay for drugs? _____

Check all used: ☐Stimulants ☐Marijuana ☐Opiates ☐Inhalants ☐Ecstasy / GHB
☐Pain Medication ☐Methadone ☐PCP ☐Barbiturates ☐Tranquilizers
☐Sedatives ☐Crystal Meth ☐Tobacco ☐Cocaine / Crack
☐Hallucinogens ☐Alcohol ☐Misuse of over the counter meds or prescribed medication

Substance Checked or Other	Type	Age of First Use	Date of Last Use	Age Regular Use Began	Current Use Pattern

☐No ☐Yes Diagnosis of Chemical Dependency/Abuse? Drug of Choice? _____

☐No ☐Yes Treatment previously received for drug use? ☐Therapy / Counseling ☐Hospitalization / Rehab

13. SEXUAL:

Has identified sexual preference as: ☐Heterosexual ☐Bi-Sexual ☐Gay / Lesbian ☐Other _____

Gender patient identifies as: ☐Female ☐Male

What is the gender designation on patient's medical insurance records? ☐Male ☐Female

(Optional) What pronouns does patient use to refer to self (eg, he, she, they)? _____

(Optional) What is patient's preferred name or nickname? _____

Patient is sexually active? ☐No ☐Yes Patient practices safe sex? ☐No ☐Yes ☐ N/A

Sexual behaviors were with / toward: ☐Same age peers ☐Younger ☐Older ☐Parents ☐Siblings
☐Opposite sex ☐Same sex ☐Both male and female ☐Animals

Sexual Behaviors (Please Check All That Apply)	Age of Patient When First Occurred	How Long Has Behavior Been Occurring?	Explain
☐Sexual preoccupation			
☐Sexually explicit talk *(not online)*			
☐Sexually explicit writings / drawings			
☐Has used electronic media for "sexting" / sex chat rooms / viewing pornography / posting inappropriate pictures of self			
☐Engaged in voyeurism / peeping *(not online)*			
☐Exposed self to others *(not online)*			
☐Sexually promiscuous *(not online)*			
☐Masturbation in presence of others *(not online)*			
☐Acted out sexually in a treatment setting			
☐Touched others sexually without their permission			
☐Sexually aggressive / predatorily			
☐Gender identity issues			

☐No ☐Yes Has experienced a sexual assault or been victimized? Age / perpetrator / circumstances: _____

_____

☐No ☐Yes Was this suspected abuse of patient reported to a State protective service?

☐No ☐Rarely ☐Mostly ☐Yes Patient is able to manage sex urges?

☐No ☐Yes Has patient received treatment for sexual behaviors? Describe: _____

_____

☐No ☐Yes Does patient have pet allergies? List: _____

☐No ☐Yes Does patient have history of aggression to animals? Describe: _____

☐No ☐Yes Does patient have history of being attacked by an animal? Describe: _____

PATIENT NAME: _____

(Place name label here)

14. BEREAVEMENT:

Relationship to Patient	Name of Person / Other	Type of Loss (Death, Divorce, Etc.)	Age of Patient at Time of Loss	How Has This Loss Affected the Patient?

15. CULTURAL INFLUENCES / RELIGIOUS BACKGROUND / CURRENT ACTIVITY:

☐No ☐Yes Patient has expressed a belief system or spirituality? _____

☐No ☐Yes Patient has a religious affiliation: _____

☐No ☐Yes Patient attends religious services? Name of church / temple? _____

☐No ☐Yes Patient's affiliation with a place of worship is part of his/her support system?

Patient and family's cultural / ethnic background? _____

☐No ☐Yes The family has specific cultural/ethnic/religions factors that should be considered during treatment?
Explain: _____

16. DIAGNOSTIC HISTORY: The patient has previously been diagnosed with:

☐Anxiety Disorder	☐Eating Disorder	☐Mood Disorder	☐Post-Traumatic Stress Disorder
☐ADHD	☐Fetal Alcohol Syndrome	☐Neurodevelopmental Disorder	☐Psychosis
☐Autism Spectrum Disorder	☐Impulse Control Disorder	☐Obsessive Compulsive Disorder	☐Reactive Attachment
☐Bipolar Disorder	☐Intellectual Disability	☐Oppositional Defiant Disorder	☐Schizoaffective Disorder
☐Cerebral Dysrhythmia	☐Intermittent Explosive Disorder	☐Paranoid Disorder	☐Substance Abuse
☐Conduct Disorder	☐Learning Disorder	☐Personality Disorder	☐Other _____
☐Disruptive Mood Dysregulation	☐Major Depressive Disorder	☐Pervasive Development Disorder	☐Other _____

17. HISTORY OF PREVIOUS TREATMENT: ☐ Last treatment more than 2 years ago

Inpatient hospitalization (Acute), Residential Treatment Center (RTC), Intensive Outpatient (IOP), Partial Hospitalization (PHP)

Name of Facility (Most Recent First)	Date(s) of Treatment	Required holds, seclusion or injections	Required 1:1 staffing	Private room due to behaviors?	Treatment Results
		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Positive ◯ Negative ◯ None
		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Positive ◯ Negative ◯ None
		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Positive ◯ Negative ◯ None
		◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Positive ◯ Negative ◯ None

****Explain any "yes" marked above:** _____

18. RESIDENCE / CONTACT INFO:

Patient's Primary Residence With: _____

Address: _____

Phone #: _____

Other #: _____

Patient's Secondary Residence With: _____

Address: _____

Phone #: _____

Other #: _____

19. PRECIPITATING EVENTS NECESSITATING TREATMENT INTERVENTIONS AT THIS TIME:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed By | Relationship to Patient | Email Address | Date