

**Western Psychological and Counseling Services, P.C.  
TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

Client Name: \_\_\_\_\_ Date \_\_\_\_\_

I voluntarily consent to assessment of my involvement with alcohol or other drugs. I affirm that the information I give is truthful and complete.

Client Signature \_\_\_\_\_

**Section I: Patient Questionnaire**

**PATIENT DIRECTIONS: PLEASE, ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE. DO NOT LEAVE BLANKS.**

**DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS**

1. Which of the following medical conditions do you currently have, or have had in the past?

Yes	N/A		TREATED	FAMILY HX		TREATED	FAMILY HX	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or blood disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic or scarlet fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or bladder infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease-hepatitis or jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer-Type _____ ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	High or low blood sugar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Last Test Date _____ Test results: _____						
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers or pains in the stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

  

<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies (food or drug).....	<input type="checkbox"/>	<input type="checkbox"/>
		If yes, to what: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Physical injury .....	<input type="checkbox"/>	<input type="checkbox"/>
		If yes, what: _____		
<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**FOR FEMALES:**

<input type="checkbox"/>	<input type="checkbox"/>	Pre Menstrual Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy: <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed		
		Number of months: _____		
		Referred to Pre-Natal care? <input type="checkbox"/> No <input type="checkbox"/> Yes		

2. Have these, or any other medical conditions been impacted by your use of alcohol or other drugs?  No  Yes  
If Yes, in what manner? \_\_\_\_\_

3. Have you ever had any surgeries or been hospitalized?  No  Yes If yes,  
Why? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_  
Why? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_  
Why? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_

Were any of these related to your use of alcohol or other drugs?  No  Yes, if so, how?  
\_\_\_\_\_

4. Do you have access to medical care?  No  Yes Provider Name \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

5. Do you routinely access medical care?  No  Yes  
Last saw a doctor for: \_\_\_\_\_ Date: \_\_\_\_\_ Outcome: \_\_\_\_\_

6. Are you currently taking any prescription medications?  No  Yes If Yes:  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Prescribed by: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_

**Western Psychological and Counseling Services, P.C.**  
**TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

7. **Current physical illnesses**, other than withdrawal, that need to be addressed or which may complicate treatment (from checklist): \_\_\_\_\_

8. How would you describe your physical health?       Poor       Average       Good       Excellent

9. Are you sexually active?    No    Yes

10. What is your body weight? \_\_\_\_\_lbs.      Are you comfortable with your weight?    No    Yes

Have you engaged in bingeing, purging, laxatives, fasting, diet pills, etc.?    No    Yes

Explain: \_\_\_\_\_

How many times per day do you eat? Describe: \_\_\_\_\_

Have you ever taken drugs to control your weight?    No    Yes   Explain: \_\_\_\_\_

---

---

**DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS**

**A. Emotional Conditions/Complications**

1. Have you ever been physically abused?    No    Yes; if yes, when and by whom: \_\_\_\_\_  
Have you received or participated in counseling for this issue    No    Yes, When and what was the outcome? \_\_\_\_\_

2. Have you ever been sexually abused?    No    Yes; if yes, when and by whom: \_\_\_\_\_  
Have you received or participated in counseling for this issue?    No    Yes, When and what was the outcome? \_\_\_\_\_

3. Have you ever been emotionally/verbally abused?    No    Yes, if yes, when and by whom: \_\_\_\_\_  
Have you received or participated in counseling for this issue?    No    Yes, When and what was the outcome? \_\_\_\_\_

4. Are there any other significant life events (losses, deaths, parental divorce, changes in schools, frequent moves, etc.)?  
 No    Yes  
If yes, describe: \_\_\_\_\_

5. Are you currently experiencing any of the following?  
 Feeling hopeless       Moodiness       Sleeplessness       Self destructive       Decreased energy  
 Preoccupation with death    Feeling Withdrawn    Taking unnecessary risks    giving away valued possessions

6. Is there any history of suicide in your family?       No    Yes, If yes, explain: \_\_\_\_\_

7. Have you ever attempted suicide?       No    Yes, If yes, when and how? \_\_\_\_\_

8. Do you currently have any suicidal thoughts?       No    Yes, If yes, how recently? \_\_\_\_\_  
What are your thoughts? \_\_\_\_\_

9. Do you currently have a plan to harm yourself?       No    Yes, If yes, describe your plan: \_\_\_\_\_

10. Have you ever engaged in self harm behaviors? Cutting, burning, etc.    No    Yes, If yes, describe: \_\_\_\_\_

**Western Psychological and Counseling Services, P.C.**  
**TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

11. When was the last time you engaged in these behaviors? Date: \_\_\_\_\_

**B. Behavioral Conditions/Complications**

1. Do you ever have homicidal thoughts?  No  Yes, if yes, explain: \_\_\_\_\_

2. Do you have any history of combative and/or assault behavior?  No  Yes; if yes, explain: \_\_\_\_\_

3. Have you ever driven a motor vehicle after consuming alcohol or any other mind/mood altering substance?  No  Yes, if yes:

How many times have you done it? \_\_\_\_\_ How often do you do it? \_\_\_\_\_ Does it concern you?  No  Yes

**Did it ever result in arrest/charges for DUI?**  No  Yes, if yes:

How many times? \_\_\_\_\_ What was the BAL/BAC at the time of arrest(s)? \_\_\_\_\_

How much did you consume before driving? \_\_\_\_\_ Over how much time? \_\_\_\_\_

How did you feel at the time of arrest? \_\_\_\_\_

What were the circumstances? \_\_\_\_\_

4. Have you ever done anything while under the influence of alcohol or other drugs that you later regretted?  No  Yes, if yes:

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

5. How much time do you spend, on average, in a typical week, in activities necessary to obtain, use or recover from the effects of using alcohol or other drugs? (spending time with friends or alone using, seeking out dealers, recovering from hangovers, etc.)

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

6. Have you ever given up or reduced important social, occupational or recreational activities because of using alcohol or other drugs?  No  Yes, if yes explain: \_\_\_\_\_

7. Describe any negative impact the use of alcohol or other drugs has had on your life. (e.g. problems with legal system, school, work, at home, relationships, health, etc.):

**C. Legal Issues**

1. Is this assessment prompted or suggested by anyone connected to the legal system?  No  Yes, If yes, who? \_\_\_\_\_  
 Your Attorney-Name \_\_\_\_\_  Judge/Court-Name \_\_\_\_\_  Other \_\_\_\_\_

2. Have you ever been arrested or charged with any crime?  No  Yes

3. Arrest history:

CHARGES	ALCOHOL/DRUG RELATED	DATE	WHERE	DISPOSITION
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			
	<input type="checkbox"/> No <input type="checkbox"/> Yes			

4. Have you ever been in jail and/or prison?  No  Yes, if yes, how many times?  
 If yes, where:

5. Are you currently on probation?  No  Yes  
 If yes, your probation officer's name: \_\_\_\_\_ Court \_\_\_\_\_  
 Release of Information (ROI) signed?  No  Yes

**Western Psychological and Counseling Services, P.C.**  
**TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

6. Have you been court ordered to participate in treatment for a Substance Related Disorder or Mental Health Disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what court issued the order? _____ Judge _____
7. Are you currently under the supervision of the Department of Corrections? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who is the person assigned to supervise your case? _____ Will you sign a release of information to allow contact with that person? <input type="checkbox"/> No <input type="checkbox"/> Yes ROI signed on _____ (date)
8. Are you a Drug Court patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes where? _____
9. If yes, are you currently in Drug Court treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, where? _____
10. Any current charges pending: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: When _____ Charge _____ Which Court? _____ When _____ Charge _____ Which Court? _____ When _____ Charge _____ Which Court? _____

**D. Cognitive Conditions/Complications**

1. Have you continued to use alcohol or other drugs despite having identified problems that were caused or made worse because of that use?  No  Yes If yes, describe: \_\_\_\_\_
  
2. Have you ever been diagnosed with any cognitive disorder?  No  Yes, if yes, when, by whom, and what was it? \_\_\_\_\_
  
3. Do you have any problems with understanding written materials?  No  Yes, if yes, what is the problem? \_\_\_\_\_  
Have you ever received any help with this problem?  No  Yes, if yes, what kind of help \_\_\_\_\_
  
4. Do you need any help to understand written or verbal information?  No  Yes, if yes, what kind of help do you need? \_\_\_\_\_

**E. Mental Health Conditions/Complications**

1. Have you had a significant period (that was not a direct result of drug/alcohol use) in which you experienced any of the following:  
 Anxiety/nervousness       Grief/loss issues       Sleep disturbances       Hostility/violence  
 Inability to comprehend       Depression       Phobias/paranoia/delusions       Loss of appetite  
 Eating disorders; if checked:  Anorexia       Bulimia       Other \_\_\_\_\_  
 Hallucinations; if checked:  Auditory       Visual  
When did you experience them and what did you do about it? \_\_\_\_\_
  
2. Is there a history of mental illness in your family?  No  Yes, If yes, who and what is the illness?  
Relative \_\_\_\_\_ Illness \_\_\_\_\_ Status \_\_\_\_\_  
Relative \_\_\_\_\_ Illness \_\_\_\_\_ Status \_\_\_\_\_  
Relative \_\_\_\_\_ Illness \_\_\_\_\_ Status \_\_\_\_\_
  
3. Have you ever been diagnosed with a mental health condition?  No  Yes, if yes what was the diagnosis? \_\_\_\_\_  
Who diagnosed it? \_\_\_\_\_ Where? \_\_\_\_\_ When? \_\_\_\_\_
  
4. Are you currently a client at a mental health center or seeing a private practitioner?  No  Yes, if yes, where/who? \_\_\_\_\_
  
5. Have you ever received counseling or psychiatric treatment?  No  Yes, If yes, where, when, and for what? \_\_\_\_\_
  
6. Are you currently using prescribed medications for mental health purposes?  No  Yes, If yes:  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_ Prescribed by: \_\_\_\_\_
  
7. Are you currently using non-prescribed drugs for mental health purposes?  No  Yes, If yes:  
Name of Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

**Western Psychological and Counseling Services, P.C.**  
**TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

Name of Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
 Name of Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

8. How would you describe your current mental health:  Poor  Average  Good  Excellent

**DIMENSION 4 READINESS TO CHANGE**

A. Chemical Dependency Treatment History			
Program Name and Location	Dates of Treatment	Treatment Completed?	Length of Abstinence
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
1. What was the reason you scheduled this appointment? <input type="checkbox"/> Family pressure <input type="checkbox"/> Employer intervention <input type="checkbox"/> Physician intervention <input type="checkbox"/> Legal pressure <input type="checkbox"/> Child custody <input type="checkbox"/> Reinstate driving privileges <input type="checkbox"/> DUI? If so, date and BAC/BAL _____ Driving Abstract available for review <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Self motivated, reason(s): _____ <input type="checkbox"/> Other reason(s): _____			
2. Do you believe you currently have a problem with the use of alcohol/drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, which? _____ Do you believe you have had a problem with the use of alcohol/drugs in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, which? _____			
3. Have you ever felt you should cut down or control your substance use? <input type="checkbox"/> No <input type="checkbox"/> Yes, if so, why? _____			
4. Have you ever tried to cut down or control your use but been unsuccessful. <input type="checkbox"/> No <input type="checkbox"/> Yes, if so, how many times? _____			
5. How would you assess your overall use of alcohol/drugs? _____			

**Readiness to Change:**

- At this moment, how important is it that you change your current drinking/drug use?  
 Not important at all.  About as important as most of the other things I would like to achieve now.  
 Most important thing in my life now
- At this moment, how confident are you that you will change your current drinking/drug use  
 I do not think I will change my drinking/drug use.  I have a 50 percent chance of changing my drinking/drug use  
 I think I will definitely change my drinking/drug use.
- Would you like to reduce or quit drinking/drug use if you could do so easily  
 No  Yes
- How seriously would you like to reduce or quit drinking/drug use altogether?  
 Not at all  Not very  Somewhat  Probably yes  Definitely yes
- Do you intend to reduce or quit drinking/using drugs in the next 2 weeks?  
 Definitely not  Probably not  Probably will  Definitely will
- What is the possibility that 12 months from now you will not have a problem with alcohol or other drugs?  
 Definitely not  Probably not  Probably will  Definitely will

DIMENSION 5: Relapse History	
1. Have you ever attempted to discontinue your use of alcohol? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how many times? _____ What is the longest time you have abstained? _____ What motivated you to abstain? _____	
2. Have you ever attempted to discontinue your use of drugs? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how many times? _____ What is the longest time you have abstained? _____ What motivated you to abstain? _____	
3. Did you resume using? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what led you to resume use? _____ How it make you feel to resume using? _____	
4. Have you ever experienced cravings to use alcohol or drugs? No <input type="checkbox"/> Yes <input type="checkbox"/> Which? _____ If yes, what are the thoughts or events that evoke cravings? _____	

**Western Psychological and Counseling Services, P.C.**  
**TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

---

---

**DIMENSION 6: RECOVERY ENVIRONMENT**

1. What jobs have you held in the last six months? \_\_\_\_\_  
Primary occupation: \_\_\_\_\_  
Last full time employment: \_\_\_\_\_
2. Which of the following employment problems have you ever experienced due to Alcohol and/or Drug use?  
 Late for work       Diminished productivity       Absenteeism       Quit  
 Fired       Used at work       none
3. Education:  
Current Grade: \_\_\_\_\_ Name of School: \_\_\_\_\_  
Principal: \_\_\_\_\_ Drug/Alcohol Counselor: \_\_\_\_\_  
Average grades this year: \_\_\_\_\_ Average grades two years ago: \_\_\_\_\_  
Have you been diagnosed with a learning disorder?  No  Yes  
Explain: \_\_\_\_\_  
Favorite Class: \_\_\_\_\_  
Goals after school is completed: \_\_\_\_\_  
\_\_\_\_\_  
Any current extra curricular activities, i.e., sports, drama, etc.?  No  Yes  
What are they? \_\_\_\_\_  
Any past extra curricular activities?  No  Yes  
What were they? \_\_\_\_\_
4. School Status:  
Is school staff involved with your assessment/referral?  No  Yes Explain: \_\_\_\_\_  
Have you been suspended?  No  Yes How many times? \_\_\_\_\_  
Have you been expelled?  No  Yes How many times? \_\_\_\_\_  
Has your chemical use affected your school in any way, i.e., performance, behavior, school sports, etc.?  No  Yes  
How has it affected your schooling? \_\_\_\_\_
5. Do you currently identify with any organized religion?  No  Yes, if yes, which: \_\_\_\_\_  
Were you raised in an organized religion?  No  Yes, if yes, which: \_\_\_\_\_  
Do you consider yourself to be a spiritual person?  No  Yes, if yes, in what ways? \_\_\_\_\_
6. Do you identify yourself with any particular cultural, ethnic background or community? No  Yes , describe \_\_\_\_\_  
Is there a particular form of support from this community you can use for your recovery?  No  Yes, describe \_\_\_\_\_  
Cultural considerations/barriers to treatment or recovery \_\_\_\_\_  
\_\_\_\_\_
7. How do you identify your sexual orientation?  
 Heterosexual  Homosexual  Bisexual  Transgender  Questioning  Declined to answer
8. Are there any barriers to accessing treatment?  No  Yes, If yes, explain: \_\_\_\_\_
9. Have you ever been involved with any self-help support group? No  Yes , if yes,  Past  Current  
Which one? \_\_\_\_\_ When? \_\_\_\_\_ Why? \_\_\_\_\_  
How do you feel about your involvement? \_\_\_\_\_  
Are you willing to attend self-help support groups now? No  Yes , if yes, which one? \_\_\_\_\_

**Western Psychological and Counseling Services, P.C.**  
**TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

10.	<u>NO</u>	<u>YES</u>	<u>COMMENTS</u>
Family history of chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Friends supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse supportive of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Living arrangements supportive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Funds for basic needs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Employment opportunities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Safe environment in home/neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	_____

11. Siblings    How many brothers and sisters do you have? \_\_\_\_\_

Name	Age	Ever used alcohol/drugs - what kinds?	Living with parents?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Parents:

Describe your relationship with your mother: \_\_\_\_\_  
 Describe your relationship with your father: \_\_\_\_\_  
 Have you ever stolen alcohol/drugs from your parents?  No  Yes  
 Family Participation  
 Who is your legal guardian? \_\_\_\_\_  
 Does your parent or guardian agree with the need for treatment?  No  Yes  
 Is your family willing to participate in the treatment process with you?  No  Yes

13. Out of home placement:

Past out of home placement and/or institutional care: \_\_\_\_\_  
 \_\_\_\_\_  
 DSHS/CPS/DCFS caseworker (if applicable) \_\_\_\_\_  
 Have you ever run away from home or other placement?  No  Yes  
 How many times have you run away? \_\_\_\_\_ Where did you go? \_\_\_\_\_  
 How long have you been on the run? \_\_\_\_\_

14. Leisure Activities:

What do you do in your leisure time? \_\_\_\_\_  
 \_\_\_\_\_  
 What kinds of activities do you participate in that involve drinking/using? \_\_\_\_\_  
 \_\_\_\_\_  
 What kinds of activities do you participate in that do not involve drinking/using? \_\_\_\_\_

15. Peer Group:

How many friends do you have? \_\_\_\_\_ How many close friends do you have? \_\_\_\_\_  
 How many of your friends use alcohol/drugs? \_\_\_\_\_ How many of your close friends use drugs or alcohol? \_\_\_\_\_  
 How many of your friends have a problem with drugs or alcohol? \_\_\_\_\_

**Western Psychological and Counseling Services, P.C.  
TWO PART YOUTH CHEMICAL DEPENDENCY EVALUATION**

**STOP:**

**RETURN YOUR COMPLETED ANSWERS TO STAFF**

Counselor Review: After the patient has completed Section I, document in a different color ink that it was reviewed face-to-face by adding any needed clarification, completing data left blank, and by signing below:

**CDP/CDPT/CADC/CADCT Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_