Perry Multi-County Juvenile Facility
PARENT QUESTIONNAIRE

Child Name: _____

- Custodial Parent/Guardian Name: _____
  Home Address:_____
  Email Address: _____
  Cell Phone (____)_____ Home phone: (____)_____ Work phone: (____)_____
- Secondary Parent/Guardian Name: _____
  Home Address:_____
  Email Address: _____
  Cell Phone (____)_____ Home phone: (____)_____ Work phone: (____)_____
- Emergency Contact Name (other than self/spouse):_____
  Phone: _____ Relationship: _____

Do you have reliable transportation to the Facility? ____ Yes ___ No

Are there any treatment barriers? ___ Yes ___ No

FAMILY RELATIONSHIPS

	Name	Age	Address	Marital Status	Educ. Level	Monthly Income	Work Times
Mother							
Father							
Step-Parent(s)							
Other Significant Adult							
Siblings							

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Who Lives within the Home? _____
Is the Child Returning to the home upon release? _____ Yes ____ No

FAMILY PROBLEM AREAS: What issues do you feel your family needs to address while involved with the Facility? How does your family normally relate to each other? What do other family members think about your Child's possible incarceration? How do you and your family typically resolve conflict?

_____

COURT INVOLVEMENT

How long has your Child been on Probation? _____

How many times has your Child been placed on House Arrest/Electronic Monitoring Device?
___ None ___ 1 ____ 2 ____ More than 2

How Many Times has your child been on Probation?
___ None ___ 1 ____ 2 ____ More than 2

Has your child ever attempted to or successfully escaped from a secure facility?
____ Yes ___ No Explain: _____

Does your child have history of assaults? Both legal and no legal involvement?
____ Yes ___ No Explain: _____

Does your Child have any unpaid Fines or Court Costs at this time?
___ Yes (Approx. Amount: $_____) ___ No

How many times has your Child been sent to JDC (Detention)?
_____ None ____ 1 ____ 2 ____ More than 2

Please explain your perception of the referring crime: _____
_____
_____

SOCIAL INFORMATION

How many of your Child's friends are/have been involved with the Court?
____ None _____ 1 - 3 _____ 3 - 5 _____ 5+

Friends' ages: ___ Mostly Older ___ Mostly Younger ___ Same Age

Has your Child had a change in friends within the past 9 months?
____ Yes ____ No

Is your Child involved with a Gang? ___ Yes ___ No ___ Not Sure
Which gang? _____

What do you think of your Child's friends? ___ Mostly Positive Influence
___ Mostly Negative Influence
___ I Don't Know their Friends

Is your Child involved in Church or any other Organized Activities?
___ Yes ___ No
What kind? _____

Has your Child ever been involved with organized athletics?
___ Yes ___ No
What kind? _____

Has your Child ever been employed? ___ Yes ___ No
Where? _____
For how long? _____
Ever been fired? ___ Yes ___ No

Has your child ever been bullied or been a bully?
___ Yes ___ No
Explain? _____

Is your Child dating? ___Yes ___ No

Do you think your Child is sexually active?
___ Yes ___ No _____ Not Sure

Do you think your Child needs information about sex, methods of birth control, &/or disease prevention?
___ Yes ___ No ____ Not Sure

EDUCATION

What is the name of the Child's school and district?
_____ Address of school: _____

What grade is your Child in? ___ 7___ 8 ___ 9 ___ 10 ___ 11 ___ 12 ___ Not Enrolled

Is your Child in any Special classes? ___ Yes ___ No
Type: _____Duration? _____

Does the Child have an IEP? ___ Yes ___ No
Explain: _____

Has your child ever repeated a grade? _____

How do you feel your Child gets along with his teachers?
___ Good ___ Fair ___ Poor

How do you feel your Child gets along with his classmates?
___ Good ___ Fair ___ Poor

What grades does your Child *usually* get?
___ A/B ____ B/C ____ C/D ____ D/F

What grades do you feel your Child is *capable* of getting?
___ A/B ____ B/C ____ C/D ____ D/F

How often does your Child bring school books home to study?
___ Daily ___ Weekly ___ Monthly ___ Occasionally

How often does your child get detention?
___ Daily ___ Weekly ___ Monthly ___ Occasionally

How often does your child get suspended from school due to behavior?
___ Weekly ___ Monthly ___ Occasionally

Has your child ever been expelled? ___ Yes ___ No
Explain: When and Why? _____

How often is your child absent from school?
____ Daily ___ Weekly ___ Monthly ___ Occasionally

How often is your child late to school?
____ Daily ___ Weekly ___ Monthly ___ Occasionally

Is your Child involved in extracurricular activities? ___ Yes ____ No
What Kind? _____

SUBSTANCE USAGE

How often does your child drink Alcoholic Beverages?
___ Daily ___ Weekly ___ Monthly ___ Occasionally/Never

How often does your child come home drunk/high?
___ Daily ___ Weekly ___ Monthly ___ Occasionally/Never

How often has your child passed out from drinking too much?
___ Daily ___ Weekly ___ Monthly ___ Occasionally/Never

How old was your child when he first drank alcohol? _____

How old was your child when he first used drugs? _____

How frequently does your child use drugs?
___ Daily ___ Weekly ___ Monthly ___ Occasionally/Never
What kinds? _____
_____

Has your child ever sold drugs? ___ Yes ___ No
Has your child ever purchased drugs? ___ Yes ___ No
Has your Child ever overdosed from drug usage? ___ Yes ___ No

What do you think about your child's alcohol or drug usage?
___ No Problem ___ Minor Problem ___ Major Problem

Has your Child ever received Substance Abuse Treatment?
___ Yes, Outpatient ___ Yes, Residential ___ No

How often do you drink alcohol?
___ Daily ___ Weekly ___ Monthly ___ Occasionally/Never

How often do you use drugs?
___ Daily ___ Weekly ___ Monthly ___ Occasionally/Never

Why do you think your child uses alcohol or other drugs?
_____
_____
_____
_____
_____

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MENTAL HEALTH

Has your Child ever been to a counselor? ___ Yes ___ No
Where? _____
When? _____
Why? _____

Do you feel it helped? ___ Yes ___ No
Why/Why not? _____

Has your Child ever:

Been a patient in a Psychiatric Hospital? ___ Yes ___ No
Threatened to kill themselves? ___ Yes ___ No
Attempted suicide? ___ Yes ___ No
Engaged in cutting/self-mutilation? ___ Yes ___ No
Threatened to kill someone else? ___ Yes ___ No
Had problems with Fire Setting? ___ Yes ___ No
Been cruel to animals? ___ Yes ___ No
Run away? ___ Yes ___ No
Beat someone up? ___ Yes ___ No
Had an explosive temper? ___ Yes ___ No
Stolen from family members? ___ Yes ___ No
Been a victim of physical/sexual abuse? ___ Yes ___ No
Witnessed domestic violence? ___ Yes ___ No
Does your child hear things others don't? ___ Yes ___ No
Does your child see things others don't? ___ Yes ___ No

Please describe a time when he lost his temper. What did he do? What happened?
_____
_____
_____
_____

Has your Child experienced any of the following Life Stresses in the past 12 months? Please check all that apply:

___ Change in school
___ Change in living arrangements
___ Death of parent
___ Death of sibling
___ Death of friend
___ Death of pet
___ Parent divorce
___ Parent remarriage
___ Family financial problems
___ Chronic illness of family member
___ Parent separation
___ New sibling
___ Other major changes:

_____
_____

Does anyone in the home/family have mental health issues? ____ Yes ____ No
Explain: _____

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MEDICAL INFORMATION

Allergies

□ Food/ Other Allergies Describe: _____
□ Medication Allergies Describe: _____
□ Special Diet Describe: _____

Exams/Past Treatment

1. Has your Child ever experienced or been diagnosed with any of the following? And if so when?

□ Asthma: _____ □ Diabetes: _____ □ Epilepsy/Seizures: _____
□ Heart Murmur: _____ □ Arthritis: _____ □ Strokes: _____
□ Weight Gain/Loss: _____ □ Cirrhosis: _____ □ Cancer: _____
□ Hepatitis: _____ □ Herpes: _____ □ Gonorrhea: _____
□ Other STD's: _____ □ Pancreatitis: _____ □ Fainting: _____
□ Lung Problems: _____ □ Kidney Disease: _____ □ Thyroid: _____
□ Frequent Vomiting: _____ □ Severe Headaches: _____ □ Mumps: _____
□ Scarlet Fever: _____ □ Rheumatic Fever: _____ □ Whooping Cough; _____
□ Diphtheria: _____ □ Tuberculosis: _____ □ Pneumonia: _____
□ High Blood Pressure:_____ □ Other Illness or Disease: _____

Immediate Family Members please indicate who and when

Heart Disease: _____ High Blood Pressure: _____
Diabetes: _____ Tuberculosis; _____
Stroke: _____ Asthma: _____
Mental Health Issues, please identify specific diagnosis _____
_____
Cancer, please identify where: _____

2. Date of Child's last Tuberculosis test: _____

3. List the Child's most current:

Physical Exam: Date: _____ Doctor:_____
Optical Exam: Date: _____ Doctor:_____
Dental Exam: Date: _____ Dentist:_____
Hearing Exam: Date: _____ Doctor: _____
Specialist Visit: Date: _____ Doctor: _____
Glasses: □ Yes □ No
Hearing Loss: □ Yes □ No
Retainer: □Yes □ No

4. List any physical limitations of your Child:

_____
_____
_____

Medical Information-Continued

5. Has your child ever been in a serious accident resulting in a serious injury:

_____
_____
_____

6. List any past surgeries and dates:

_____
_____
_____

7. List all medicines and pills prescribed

Is the child currently taking these meds? Yes or No (circle one)

Medicine Dosage

_____
_____
_____
_____
_____

Please use this space for any additional information or comments:

What would you like to see change about your Child?

_____
_____
_____

Do you have any other comments or questions?

_____
_____
_____

Signature of Parent/Guardian completing this form:

_____

Signature Date

Relationship to the child: _____