



Consent for Logan River Academy to release information from the records of:

Client Name Date of Birth

Logan River Academy is released from all liability that may arise from the release of information authorized. I understand that the records may contain diagnosis, treatment and prognosis with respect to physical or mental conditions, to include records of alcohol and drug abuse, communicable disease, and/or treatment.

A photocopy of this authorization shall be effective as an original.

Release Logan River Academy Records to:

Education Consultant/ Referring Professional	Name:	Please circle: Verbal Written Treatment Reviews Other:	Duration: Discharge 60 days post D/C Other:
	Address:		
	City/State/Zip:		
	e-mail:		
	Phone:		

I understand that the records are protected and cannot be disclosed without my permission. Alcohol/drug treatment records by federal regulation 42 CFR, part 2. I also understand that my consent for disclosure is subject to my written revocation. I cannot take exception to actions that have taken place before I withdrew consent. The consents are limited to the respective time frames listed above.

Parent/Guardian Date Client Signature (when necessary)



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Date of Birth

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Release Logan River Academy Records to:

Purpose of Disclosure	Address and Phone Number	Type of Information	Expiration
	Name: Address: City/State/Zip: E-mail: Phone:	Verbal Reports Tx Reviews Other:	Discharge 60 days post DC Other: _____
	Name: Address: City/State/Zip: E-mail: Phone:	Verbal Reports Tx Reviews Other:	Discharge 60 days post DC Other: _____
	Name: Address: City/State/Zip: E-mail: Phone:	Verbal Reports Tx Reviews Other:	Discharge 60 days post DC Other: _____

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Parent/Guardian

Date

Client Signature (where necessary)

Logan River Academy
PARENTAL PERMISSION FOR EVALUATION

 Student

In order to obtain information for educational services, we need your permission to conduct an evaluation. Examples of proposed tests and their purposes are indicated below. We may not need to give all of these tests. We will not give any test without your consent.

INTELLECTUAL	Tests in this area measure a student's ability to remember what has been seen, heard and the ability to solve problems. They also reflect learning rate and assist in predicting how well a student will do in school. Tests such as: Wechsler Scales of Intelligence or Woodcock Johnson - Revised: Part 1
ACADEMIC	Tests in this area measure a student's current reading, mathematics, written expression and readiness skills. Tests such as: Kaufman Test of Educational Achievement, Woodcock Johnson - Revised: Part 2, KeyMath - Revised, Woodcock Reading Mastery Tests Revised or Peabody Individual Achievement Test - Revised.
COMMUNICATION	Tests in this area measure a student's ability to understand, relate to and use language or speech appropriately. Tests such as: Goldman-Fristoe Test of Articulation or Test of Adolescent Language 3.
SOCIAL EMOTIONAL	Tests in this area assess a student's personal independence and social functioning in home, school and community. They also assess behavioral patterns that may adversely affect educational performance. Tests such as: Rorschach, Conners Rating Scale, Burk's Behavior Scale, Sentence Completion, Achenbach, Bender Gestalt, Draw A Person, Personal History Inventory or Direct Observation.
HEARING /VISION	Tests in hearing assess sensitivity, visual screen acuity and processing abilities
VOCATIONAL/TRANSITION	Tests in this area are used to identify career strengths, limitations and interests. They also help to identify present functioning levels for life skills, habits and attitudes relating to vocational performance. Tests such as: Strong Interest Inventory or California Occupational Preference Survey.
OTHER	Specify:

This evaluation will be initiated when your written permission is received. You have the right to refuse permission for this evaluation. All tests will be administered in English. Upon request, you may review or be informed of the testing results.

_____ DO authorize the evaluation requested for my child.

_____ I DO NOT authorize the evaluation requested for my child.

 Parent/Guardian Signature

 Date

Logan River Academy

REQUIREMENTS GOVERNING THE RESTRICTIONS OF MAIL, TELEPHONE CALLS, AND VISITS

Dear Parents,

As a concerned parent, you may wish to prevent your child from receiving mail, telephone calls, or visits from persons whom you believe may influence him/her negatively; this is your right, and we urge you to exercise it as appropriate.

Please list on this form the names and addresses (if known) of all persons who should be prevented from contacting your child. Incoming mail, telephone calls, and visits from these individuals will be refused. Please note, however, that Logan River Academy has no legal authority to restrict contact from any other person other than those specifically named in the document. **GENERAL RESTRICTIONS CANNOT BE IMPOSED** (i.e., "everyone except Mom, Dad, Grandma, etc."). The list can be updated as necessary with your authorization.

PLEASE NOTE: Legal rights of visitation of a parent cannot be restricted by the other parent unless accompanied by a restraining order. **(A client's outgoing mail cannot be restricted.)**

CORRESPONDENCE/VISIT/TELEPHONE RESTRICTION LIST

I hereby forbid correspondence, visits, and telephone contacts from the following persons with my child.

Client Name	Signature of Parent/Guardian
Date	Date

Name	Address	Relationship to Client	Approx Age	Letters	Visits	Phone Calls

NOTE: All restrictions will be reviewed at least every 30 days for effectiveness and continued need. Reviews will be documented on the Treatment Plan Review form.

Logan River Academy

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STUDENT'S PERSONAL HISTORY

STUDENT'S NAME: _____

Please state in your own words the nature of your child's present problems and previous difficulties, including when the difficulties were first noticed and by whom (i.e., teacher, doctor, family, friend) and what recent events or behavior brought about your request for enrollment. Please use an additional sheet if needed.

HOME: _____

SCHOOL: _____

LEARNING DISABILITIES (type & description) _____

LEGAL ISSUES: _____

SUBSTANCE ABUSE(type): _____

STUDENT'S STRENGTHS & ATTRIBUTES: _____

STUDENT'S HOBBIES & SPECIAL INTEREST: _____

RELIGIOUS

MEDICAL/DENTAL HISTORY

Student's Name: _____ Age: _____

IMPORTANT: Complete every question on both sides of this form.	YES	NO	If yes, refer to item by number, explain when the problem occurred, and give details of present condition, including: current medication.
DOES YOUR CHILD HAVE OR HAS HE/SHE EXPERIENCED DURING THIS PAST YEAR:			
1. Ear pain or any problem with hearing?			
2. Eye discomfort or difficulty?			
3. Frequent headaches?			
4. Dizziness or fainting spells?			
5. Hay fever or nasal problems?			
6. Hives or skin allergies?			
7. Skin sores or rashes?			
8. Warts or sores on feet?			
9. A lump, mole, or swelling?			
10. Coughing?			
11. Chest pain or shortness of breath?			
12. Spitting or coughing: up blood?			
13. Sweating at night?			
14. Stomachaches, burning, or indigestion?			
15. Urinary burning, frequent urination, or dark urine?			
16. Difficulty in starting: urine or dribbling?			
17. Enuresis (bed-wetting)?			
18. Pain in back, neck, joints?			
19. Difficulty walking:, running or lifting things?			
20. A rupture or hernia?			
21. Unexplained weight loss (including eating disorder) or weight gain?			
22. Pain or bleeding when having bowel movements?			
23. Diarrhea or unusual bowel movements?			
24. Any illness or injury not already noted?			
FEMALES ONLY:			
25. A vaginal discharge?			
26. Painful menstruation or irregular periods?			
27. Spotting: between periods?			
28. Flowing longer than 8 days?			
29. Date of last menstrual period?			
HAS CHILD EVER HAD:			
30. Venereal disease?			
31. A knee or ankle injury?			
32. Broken bones and/or deformities?			
33. Arthritis or swollen, painful joints?			
34. Birthmarks and/or tattoos?			
35. Glasses and/or contact lenses?			
36. Any orthopedic appliance (back brace, orthotics)?			
37. Orthodontics (dental braces)?			
38. A back injury or deformity?			
39. An ulcer?			
40. Surgery or hospitalizations not noted above?			
41. Any other acute or chronic health problems?			
HAS CHILD OR IMMEDIATE FAMILY MEMBER (parent, grandparent, brother or sister) EVER HAD: If so, explain who:			
42. Tumor, growth, cyst, or cancer?			
43. Heart disease or heart murmur?			
44. Diabetes or sugar in the urine?			
45. High blood pressure?			
46. Asthma or wheezing?			

UTAH SCHOOL IMMUNIZATION RECORD

This record is part of the student's permanent school record (cumulative folder) as defined in Section 53A-11-304 of the Utah Statutory Code and shall transfer with the student's school record to any new school. The Utah Department of Health and local health departments shall have access to this record. This immunization record may be entered into the Utah Statewide Immunization System (USIIS). For more information about USIIS, please visit the USIIS website at <http://www.usiis.org/index.shtml> or see the Family Educational Rights and Privacy Act (FERPA) directory.

INSTRUCTIONS: This form must be completed for enrollment in schools and early childhood programs (i.e. a nursery or preschool, licensed day care center, child care facility, family home care, or Head Start Program.). See reverse side for instructions on claiming exemptions for medical, religious, or personal reasons.

Student Name _____ Gender: Male ___ Female ___ Date of Birth _____
 Name of Parent/Guardian _____ Signature of Parent/Guardian _____
 Mailing Address _____ City _____ Zip Code _____ Telephone _____
 Does child have health insurance? YES ___ NO ___ Name of Insurance _____
 If no health insurance, would you like to be contacted about health coverage for children? YES ___ NO ___

VACCINE	Record the month, day & year vaccine was given.				
	1st	2nd	3rd	4th	5th
DTP, DTaP, DT, Td (D = Diphtheria; T=Tetanus; P=Pertussis; aP=acellular Pertussis).					
Td Booster				Pertussis is not required for 7 th grade entry, but Tdap products can be used for Td requirement.	
Haemophilus Influenza b (Hib)					
Polio (IPV or OPV)					
Measles, Mumps, and Rubella (MMR)* 1st dose must be received on or after the 1st birthday			*If Vaccine is given in the combined form (MMR), enter the complete date in the appropriate MMR box. **If vaccine is given as a single antigen, enter the date(s) in the appropriate boxes.		
Measles (Rubeola - 10 day, red measles)**					
Mumps **					
Rubella (German Measles - 3 day measles) **					
Hepatitis B (HBV)					
Varicella (Chickenpox) Must be received on after the 1 st birthday.				If a student has had the Chickenpox disease, parent must sign to the right.	
Hepatitis A 1 st dose must be received on or After the 1 st birthday.					

SCHOOL AND EARLY CHILDHOOD PROGRAM USE ONLY:
1. Date of Unconditional Admission: _____ ALL REQUIREMENTS MET
2. Date of Conditional Admission: _____
3. Exemption was granted for: <input type="checkbox"/> Medical Reason <input type="checkbox"/> Religious Reason <input type="checkbox"/> Personal Reason
4. Date Immunizations verified by <input type="checkbox"/> Physician Record <input type="checkbox"/> Parent Record <input type="checkbox"/> Health Dept. Record

My student has had the chickenpox disease, and therefore, does not need the Varicella vaccine.
Signature of Parent/Guardian: _____
Today's Date _____

I have reviewed the records available and, to the best of my knowledge, this student has received the above immunizations.

Authorized Signature _____ Date _____
 ___ Physician ___ School or Early Childhood Program Official ___ Health Authority

Utah Department of Health
 Division of Community and Family Health Services
 Immunization Program 01/06

INSTRUCTIONS

1. **The minimum required immunizations for school or early childhood program entry include:**
 - **5 doses of DTaP/DTP/DT** - 4 doses are acceptable if the 4th dose was given after the 4th birthday; 3 td required if started after age 7.
 - **1 Booster dose of Td** – EFFECTIVE JULY 1, 2006, required for students born after July 1, 1993, prior to 7th grade entry.
 - **4 doses of Polio** - 3 doses are acceptable if the 3rd dose was given after the 4th birthday;
 - **2 doses of Measles** - required for all students kindergarten through grade 12. Two doses of Measles, Mumps, and Rubella (MMR) vaccine are acceptable. The first dose of measles containing vaccine must be given on or after the 1st birthday.
 - **1 dose of Mumps** - must be given on or after the 1st birthday.
 - **1 dose of Rubella** - must be given on or after the 1st birthday.
 - **4 doses of Haemophilus Infuenzae type b(Hib)** - dosing schedule is based upon student's current age and number of previous doses received. Hib is not required for kindergarten entry.
 - **3 doses of Hepatitis B** - required for students born after July 1, 1993 prior to entering kindergarten. EFFECTIVE JULY 1, 2006, required for students born after July 1, 1993, prior to 7th grade entry.
 - **1 dose of Varicella (chickenpox)** – required for students born after July 1, 1996 prior to entering kindergarten. EFFECTIVE JULY 1, 2006 - required for students born after July 1, 1993 prior to 7th grade entry. It must be given on or after the 1st birthday. Parental history of the disease is acceptable. Parent/Guardian must sign verifying history of disease.
 - **2 doses of Hepatitis A** - required for students born after July 1, 1996 prior to entering kindergarten. The first dose of Hepatitis A must be given on or after the 2nd birthday.
2. **Fill in (print or type) student's name, gender, date of birth.**
3. **Fill in (print or type) name of parent/guardian, mailing address, city, zip code, and telephone number. Parent/Guardian must sign.**
4. **Written proof is required to verify the student's immunizations.** Proof may be obtained from physician records, health department records, or parent/guardian records. Parent/guardian records may be accepted if they indicate the student's name, date of birth, type of vaccine administered, specific dates of immunization, and the name of physician or health care facility administering the vaccine.
5. **Transcribe the month, day, and year of each immunization received by the student in the appropriate box.**
6. **Complete the "SCHOOL AND EARLY CHILDHOOD PROGRAM USE ONLY" box..**
 - a. Determine if admission requirements for all immunizations have been met. If all requirements have been met, enter "Date of Unconditional Admission - ALL REQUIREMENTS MET." If all admission requirements have not been met, but the student has received at least one dose of each vaccine, enter "Date of Conditional Admission" and explain the process of completing required immunizations to parent/guardian.
 - b. If a student is exempted for medical reasons and the duration of the medical condition is temporary, enter "Date of Conditional Admission." Upon termination of such exemption, immunizations shall be required. If the medical exemption is permanent, the student shall be considered as having met all requirements. Complete date for ALL REQUIREMENTS MET and check the box marked medical exemption granted.
 - c. If a student is exempted for personal or religious beliefs, the student shall be considered as having met all requirements. Complete date for ALL REQUIREMENTS MET and check the box marked religious or personal exemption granted.
 - d. Fill in date(s) immunization records were verified.
7. **Complete authorized signature and date.**
8. **Exemption Procedures:**
 - a. **MEDICAL EXEMPTION:** If a medical exemption is claimed, a Medical Exemption Form must be completed and signed by the student's licensed physician (Utah Statutory Code - Section 53A-11-302). The Medical Exemption Form may be obtained from the student's physician. It must indicate whether the exemption is to one or all immunizations. The WHITE and YELLOW copies will be given to the parent/guardian. The parent/guardian will present the WHITE copy to the school or early childhood program official. The WHITE copy must be attached to this record. The YELLOW copy is for the parent/guardian. The PINK copy will remain in the child's medical record.
 - b. **RELIGIOUS EXEMPTION:** If a religious exemption is claimed, a Religious Exemption Form must be completed and signed by the parent/guardian. The Religious Exemption Form may be obtained from a local health department. A local health department representative must witness and sign the Religious Exemption Form giving the WHITE and YELLOW copies to the parent/guardian. The parent/guardian will present the WHITE copy to the school or early childhood program official. The WHITE copy must be attached to this record. The YELLOW copy is for the parent/guardian. The PINK copy will remain with the local health department.
 - c. **PERSONAL EXEMPTION:** If a personal exemption is claimed, a Personal Exemption Form must be completed and signed by the parent/guardian. The personal Exemption Form may be obtained from a local health department. A local health department representative must witness and sign the Personal Exemption Form giving the WHITE and YELLOW copies to the parent/guardian. The parent/guardian will present the WHITE copy to the school or early childhood program official. The WHITE copy must be attached to this record. The YELLOW copy is for the parent/guardian. The PINK copy will remain with the local health department.

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO:

FROM:

SECTION I - IDENTIFYING DATA

Notice is given of intent to place - Name of Child:			Ethnicity: Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to determine/unknown	
Social Security Number:		ICWA Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White	
Sex:	Date of Birth	Title IV-E determination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending		
Name of Mother:			Name of Father:	
Name of Agency or Person Responsible for Planning for Child:				Phone:
Address:				
Name of Agency or Person Financially Responsible for Child:				Phone:
Address:				

SECTION II - PLACEMENT INFORMATION

Name of Person(s) or Facility Child is to be placed with:			Soc Sec # (optional): Soc Sec # (optional):	
Address:			Phone:	
Type of Care Requested:		<input type="checkbox"/> Parent <input type="checkbox"/> Relative (Not Parent) Relationship: _____ _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> ADOPTION <input type="checkbox"/> IV-E Subsidy <input type="checkbox"/> Non IV-E Subsidy To Be Finalized In: <input type="checkbox"/> Sending State <input type="checkbox"/> Receiving State	
<input type="checkbox"/> Foster Family Home	<input type="checkbox"/> Residential Treatment Center			
<input type="checkbox"/> Group Home Care	<input type="checkbox"/> Institutional Care-Article VI, Adjudicated Delinquent			
<input type="checkbox"/> Child Caring Institution				
Current Legal Status of Child:		<input type="checkbox"/> Protective Supervision		
<input type="checkbox"/> Sending Agency Custody/Guardianship		<input type="checkbox"/> Parental Rights Terminated-Right to Place for Adoption		
<input type="checkbox"/> Parent Relative Custody/Guardianship		<input type="checkbox"/> Unaccompanied Refugee Minor		
<input type="checkbox"/> Court Jurisdiction Only		<input type="checkbox"/> Other:		

SECTION III - SERVICES REQUESTED

Initial Report Requested (if applicable): <input type="checkbox"/> Parent Home Study <input type="checkbox"/> Relative Home Study <input type="checkbox"/> Adoptive Home Study <input type="checkbox"/> Foster Home Study	Supervisory Services Requested: <input type="checkbox"/> Request Receiving State to Arrange Supervision <input type="checkbox"/> Another Agency Agreed to Supervise <input type="checkbox"/> Sending Agency to Supervise		Supervisory Reports Requested: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Upon Request <input type="checkbox"/> Other:	
Name and Address of Supervising Agency in Receiving State:				
Enclosed: <input type="checkbox"/> Child's Social History <input type="checkbox"/> Court Order <input type="checkbox"/> Financial/Medical Plan <input type="checkbox"/> Other Enclosures <input type="checkbox"/> Home Study of Placement Resource <input type="checkbox"/> ICWA Enclosure <input type="checkbox"/> IV-E Eligibility Documentation				

Signature of Sending Agency or Person:			Date:
Signature of Sending State Compact Administrator, Deputy or Alternate:			Date:

SECTION IV - ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

<input type="checkbox"/> Placement may be made	<input type="checkbox"/> Placement shall not be made
REMARKS:	
Signature of Receiving State Compact Administrator, Deputy or Alternate:	
Date:	

DISTRIBUTION (Complete six (6) copies):
 • Sending Agency retains a (1) copy and forwards completed original plus four (4) copies to:
 • Sending Compact Administrator, DCA, or alternate retains a (1) copy and forwards completed original and three (3) copies to:
 • Receiving Agency Compact Administrator, DCA, or alternate who indicates action (Section IV) and forwards a (1) copy to receiving agency and the completed original and one (1) copy to sending Compact Administrator, DCA, or alternate within 30 days.
 • Sending Compact Administrator, DCA, or alternate retains a completed copy and forwards the completed original to the sending agency.

INSURANCE BENEFIT FORM

It is our policy at Logan River Academy to help parents access their insurance benefit on/or before admission. If the benefits have not been verified and the pre-authorization has not been completed as part of the admissions process, LRA will not be able to pursue those benefits after admission. Due to the procedures that insurance companies follow, it almost guarantees denial of any claims when we do not go through correct channels prior to admission.

I have checked into my insurance policy and found that there is not a benefit for this level of care. Please admit my child as a private pay.

_____ this _____ day _____, 200__.
(sponsor)

I have not checked with my Insurance to see if there is a benefit. I would appreciate it if Logan River Academy could check on this for us. It is understood that we are responsible for payment of the account, until payment is received from the insurance company.

_____ this _____ day _____, 200__.
(sponsor)

**Insurance Benefits do not guarantee payment of claim.

If you would like Logan River Academy to call and verify benefits please make a front and back copy of the insurance card(s), both primary and secondary if applicable, and forward to LRA as soon as possible. Please include both medical and dental cards if they are a separate benefit.

If you have any questions, please call Wendy Farr at 435-755-8400, or contact at wfarr@loganriver.com. Thank you

PARENT SUBSTANCE INDEX (PSI)

(Please circle YES or NO to each answer as best you know. Alcohol and nicotine are considered drugs)

Has your child ever:

- A-1:_ skipped school? YES NO
- A-2:_ failed assignments or class? YES NO
- A-3:_ been suspended or expelled because of drugs or behavior related to drug use? YES
NO
- A-4:_ had learning disabilities or trouble in school? What:_____ YES NO
- S-5: given up sober friends for those who used drugs? YES NO
- S-6: lost interest in activities, sports, hobbies, or other interests? YES NO
- S-7: changed habits, dress, music, or appearance? YES NO
- S-8: chooses older friends? YES NO
- S-9: has become sexually active? YES NO
- P-10: had increased health problems: colds, rashes, breathing, memory, etc? YES NO
- P-11: had sexually transmitted diseases, pregnancy, abortion? YES NO
- P-12: had noticeable bloodshot eyes or skin acne or rashes? YES NO
- E-13: become uncharacteristically withdrawn or depressed? YES NO
- E-14: become noticeable testy, irritable, suspicious, or paranoid? YES NO
- E-15: become uncharacteristically angry, belligerent, or defiant? YES NO
- B-16: became involved in illegal, criminal acts: stealing, burglary, etc? YES NO
- B-17: been arrested, cited, or apprehended for breaking laws or rules? YES NO
- B-18: admitted to or was caught by you using drugs or paraphernalia? YES NO
- B-19: become noticeably aggressive, assaultive, or threatening to you or peers? YES NO
- B-20: done dangerous, crazy, or physically hazardous behavior? YES NO
- B-21: stolen or highly suspected of stealing from you or other family members? YES NO
- B-22: had problems finding, keeping, or succeeding at a job? YES NO
- B-23: lacks motivation doesn't try, or quits tasks easily? YES NO
- B-24: gone long periods without sleep, or confused sleep patterns? YES NO
- F-25: openly opposes parental authority and defies family rules? YES NO
- F-26: isolates self from family and does not participate in activities? YES NO
- F-27: receives or makes secretive phone calls at all hours? YES NO
- F-28: history of family addiction? Who:_____ YES NO
- V-29: compromised personal, family, and social values? YES NO
- V-30: lost faith or interest in religion, church or spiritual belief? YES NO
- V-31: sold or trafficked drugs? YES NO
- D-32: abused alcohol or drugs of any kind to your knowledge? YES NO
- D-33: if yes: has the amount of drugs used increased? YES NO
- D-34: if yes: have they been unable to cut down or quit? YES NO
- D-35: if yes: do they show heavy preoccupation with drugs and culture? YES NO
- D-36: if yes: do they continue use despite recurring problems? YES NO
- D-37: if yes: been unable to fulfill major role functions at home/school/social? YES NO
- D-38: ever been treated for addiction or abuse prior to this placement? YES NO
- D-39: had psychological problems (depression, disorders) in the past? YES NO
- D-40: overdosed or attempted/threatened suicide? YES NO

Parent Signature:_____

Youth Outcome Questionnaire (Y-OQ®2.01)

Child's Name _____ ID# _____ Today's Date _____
 Child's Date of Birth _____ Child's Sex: Male _____ Female _____ Parent/Guardian _____

PURPOSE: The Y-OQ®2.01 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®2.01 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

DIRECTIONS: - Read each statement carefully.
 - Decide how true this statement is for your child prior to most recent treatment. Check the box that most accurately describes your child during the past week. Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

My Child:

1. Wants to be alone more than other children of the same age
2. Complains of dizziness or headaches.....
3. Doesn't participate in activities that were previously enjoyable
4. Argues or is verbally disrespectful.....
5. Is more fearful than other children of the same age
6. Cuts school or is truant.....
7. Cooperates with rules and expectations
8. Has difficulty completing assignments, or completes them carelessly.....
9. Complains or whines about things being unfair
10. Experiences trouble with her/his bowels, such as constipation or diarrhea.....
11. Gets into physical fights with peers or family members
12. Worries and can't get certain ideas off his/her mind.....
13. Steals or lies
14. Is fidgety, restless, or hyperactive.....
15. Seems anxious or nervous
16. Communicates in a pleasant and appropriate manner.....
17. Seems tense, easily startled
18. Soils or wets self.....
19. Is aggressive toward adults
20. Sees, hears, or believes things that are not real.....
21. Has participated in self-harm (e.g. cutting or scratching self, attempting suicide)
22. Uses alcohol or drugs.....
23. Seems unable to get organized
24. Enjoys relationships with family and friends.....
25. Appears sad or unhappy
26. Experiences pain or weakness in muscles or joints.....
27. Has a negative, distrustful attitude toward friends, family members, or other adults
28. Believes that others are trying to hurt him/her even when they are not.....
29. Threatens to, or has run away from home
30. Experiences rapidly changing and strong emotions.....

	For Office Use Only					
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29						
30						

My Child:	Never or Almost Never	Rarely	Sometimes Frequently	Almost Always or Always	ID	S	IR	SP	BD	CI
31. Deliberately breaks rules, laws, or expectations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
32. Appears happy with her/himself.....	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1						
33. Sulks, pouts, or cries more than other children of the same age	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
34. Pulls away from family or friends.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
35. Complains of stomach pain or feeling sick more than other children of the same age	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
36. Doesn't have or keep friends.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
37. Has friends of whom I don't approve	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
38. Believes that others can hear her/his thoughts, or that s/he can hear the thoughts of others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
39. Engages in inappropriate sexual behavior (e.g. sexually active, exhibits self, sexual abuse towards family members or others)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
40. Has difficulty waiting his/her turn in activities or conversations.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
41. Thinks about suicide, says s/he would be better off if s/he were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
42. Complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from - sleep too early.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
43. Complains about or challenges rules, expectations, or responsibilities	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
44. Has times of unusual happiness or excessive energy.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
45. Handles frustration or boredom appropriately	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1						
46. Has fears of going crazy.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						XXX
47. Feels appropriate guilt for wrongdoing	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1						
48. Is unusually demanding.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
49. Is irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
50. Vomits or is nauseous more than other children of the same age.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
51. Becomes angry enough to be threatening to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
52. Seems to stir up trouble when bored.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
53. Is appropriately hopeful and optimistic	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1						
54. Experiences twitching muscles or jerking movement in face, arms, or body.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
55. Has deliberately destroyed property	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
56. Has difficulty concentrating, thinking clearly, or attending to tasks.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
57. Talks negatively, as though bad things are all his/her fault	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
58. Has lost significant amounts of weight without medical reason.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
59. Acts impulsively, without thinking of the consequences	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
60. Is usually calm.....	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1						
61. Will not forgive her/himself for past mistakes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
62. Lacks energy.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
63. Feels that he/she doesn't have any friends, or that no one likes him/her	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
64. Gets frustrated and gives up, or gets upset easily.....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3						
This Page Subtotals...										
Side 1 Subtotals										
SUBSCALE TOTALS										
(Sum of Subtotals)										

TOTAL =