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:** _____

Expectations for Treatment:

RTC treatment is one of the most restrictive treatment levels and over time this can have a negative impact on development and family relations. Meridell's specific program is designed to be 45-90 days. Children will typically attain the maximum benefit by that point. We have found longer stays tend to lead to regression and/or diminishing returns as other patients discharge/transfer and new patients admit.

18. Please share a summary of your expectations for your child's treatment progress and what criteria you believe will indicate their readiness to return home or to a lower treatment level?

19. Based on your knowledge of your child, what treatment duration do you anticipate would stabilize your child's symptoms in order to step down to a lower treatment level?

PATIENT NAME: _____

(Place name label here)

Aftercare Needs:

20. What community based resources have you utilized for your child (in home services, specialized services e.g. ABA, parent advocates/ed consultants, PHP, therapeutic schools and programs)?

21. What level of support do you believe your child will need in the community in order to return home successfully? Do you have the resources to access those supports?

22. What barriers do you have providing supports to your child upon return home e.g. transportation, work schedule, lack of family support, safety of other family members in the home, medical issues etc.?

23. PRECIPITATING EVENTS NECESSITATING TREATMENT INTERVENTIONS AT THIS TIME:

24. RESIDENCE / CONTACT INFO:

Patient's Primary Residence With: _____

Address: _____

Phone #: _____

Other #: _____

Patient's Secondary Residence With: _____

Address: _____

Phone #: _____

Other #: _____

Completed By	Relationship to Patient	Email Address	Date