QUESTIONNAIRES

How to Administer the Questionnaire(s) Child and Parent
(Basic and Advanced for Early Identification)

The Basic and Advanced Early Identification Questionnaires are to be completed by the youth with a clip board and pen, or the Youth Diversion Coordinator can ask the questions face-to-face and document the answers.

PURPOSE: The purpose for questionnaires is to help identify if the child accepts responsibility and accountability for their actions. The advanced questionnaire will help identify a child who may be struggling with mental health and/or substance abuse issues, or something else.
Parent questionnaires will provide you with additional information to help you determine what is the best diversion strategy for the child and if an immediate referral to a professional is needed.

When should you administer the advanced questionnaire? After the applicant completes the basic questionnaire and **doesn't** show remorse, a willingness to accept responsibility or accept accountability for their actions, then the Advanced Early Identification Questionnaire is recommended.

IMPORTANT: Any indication of serious mental health concerns or substance abuse should result in an **immediate referral to a professional for an assessment, clinical evaluation and/or treatment.**

If the child does not present a need for an immediate intervention or needs to be referred to a professional for assessment or clinical evaluation and/or treatment, then an educational course that closely matches their Class 'C' offense along with attending a 'Live' Peer Group Mentoring session may be recommended as your diversion strategy.
(List of Educational Recommendations is available on Page 38)

QUESTIONNAIRES
BASIC AND ADVANCED

Basic Questionnaire is designed to look for accountability and remorse for their actions.
Advance questionnaire aims to identify and respond to at-risk youth and those with substance issues and/or mental illness.

BASIC QUESTIONNAIRE - Child
Basic Questionnaire (BQ) has 12 questions designed to gather basic details about the youth's involvement in the offense and their accountability for their actions. This questionnaire will also show if the child shows remorse and accepts responsibility for their actions. It will also help identify if the child need may need to complete the 25 question Advanced Early Identification Questionnaire.

ADVANCED QUESTIONNAIRE - Child
Advanced Early Identification Questionnaire (AEIQ) is more detailed with 25 questions and aims to gather more feedback and information to help identify at-risk youth who may be living with substance use and abuse issues and/or mental illness.

BASIC QUESTIONNAIRE - Parent
ADVANCED QUESTIONNAIRE - Parent

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BASIC QUESTIONNAIRE - Child

Basic Information: **Date:** ________ Time: ______

- **Your Name:** ____
- **Your address (where you live):** ____________________________________
- **Your Date of Birth:** ____________________
- **Name of your School/Grade Level:** ____________________ ____________________
  School Name Your Grade Level
- **Name of Your Parent or Guardian:** ____________________________________
- **Your Phone #:** ____

1. Give details about why you are here today:

____

____

2. Were other people involved in your situation? Friends? Family? Yes No
If 'yes' please provide details:

____

____

3. Was anyone in your family disappointed by your actions? Yes No
If 'yes', who was disappointed and how did you know they were disappointed? What did they say or do?

____

____

4. Emotionally, describe how much this incident has cost you? (worry, fear, anxiety, embarrassment, regret, sadness, sleep loss, etc.)

____

____

5. Describe how this incident has changed your life. You can put down something positive or negative.

____

____

6. If you could do it all over again, what would you have done differently?

____

____

7. List two positive changes you want to make in your life:

____

____

8. What are the reasons you want to make these positive changes?

____

____

9. What are the steps you plan on taking to make these changes?

____

____

10. List 2 things or people that will get in the way of your changes?

____

____

11. What do you plan to do if your plan isn’t working?

____

____

12. On a scale of 1 to 10, how bad do you feel about your situation?

1-2	3-5	6-8	9-10
I don’t feel bad	I feel a little bad	I feel bad	I feel really bad

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Advanced Early Identification Questionnaire (AEIQ) (Child) 25 Questions

IMPORTANT: When speaking to a youth who may have had thoughts of hurting themselves or others, it's important to approach the conversation with care, empathy, and non-judgment.

1. Have you ever been in trouble with the law before? (circle one) Yes No
If 'yes', please give details:

____

____

2. Do you often feel sad, hopeless, or irritable? (circle one)
    - Never
    - Sometimes
    - Frequently

3. Do you have difficulty concentrating at school or completing assignments? (circle one)
    - No
    - Occasionally
    - Often

4. Do you have a good group of friends at school you connect with? Yes No
If yes, please describe.

5. Are you failing any classes at school? Yes No
If yes, please explain.

6. Do you plan on graduating high school: Yes No
If 'no', please explain.

7. Do you participate in any extra-curricular school activities? Yes No
If 'yes', what kind of activities are you involved in?

8. Have you experienced any major changes in your sleep (sleeping too much or too little)? Yes No
If 'yes', why do you think you are having issues with your sleep?

____

9. Have you lost interest in activities you used to enjoy? Yes No
If 'yes', why do you think? ____

____

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10. Do you often feel anxious, worried, or overwhelmed by stress? (circle one)
No
Sometimes
Frequently

11. What things or people make you feel anxious, worried, or overwhelmed?

12. Lately, have you experienced panic attacks (feeling very scared or anxious all of a sudden)? Yes No
If 'yes', please describe: ____

____

13. Have you been through any difficult or traumatic experiences recently (for example: the loss of a loved one, being abused, being bullied)?
If yes, please describe: ____

____

14. Have you had any thoughts of hurting yourself? Yes No
If yes, please describe: ____

____

15. Have you had any thoughts of hurting others? Yes No
If yes, please describe: ____

____

16. How many times per week do you get really angry? (circle one)
Never
Occasionally (1 – 3 times per month)
Regularly (1-2 times a week)
Frequently (more than 2 times a week)

17. Have you ever used any drugs (including marijuana, tobacco, nicotine/vape, or prescription medications not prescribed to you)? Yes No
If yes, how often? (circle one)
Occasionally (1–3 times a month)
Regularly (1–2 times a week)
Frequently (more than 2 times a week)

18. Have you ever consumed alcohol (including beer, wine, or liquor)? Yes No
If yes, how often? (circle one)
Occasionally (1 – 3 times a month)
Regularly (1 – 2 times a week)
Frequently (more than 2 times a week)

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19. Do you use drugs or alcohol to cope with stress, anxiety, or sadness? Yes No

20. Have you ever gotten into trouble (at school or with the law) because of alcohol or drug use?

Yes No

21. Do you believe you have family members who are currently struggling with substance abuse or mental health issues? Yes No
If yes, please explain.

22. How would you rate your home environment? 10 being the best. (circle)

1 2 3 4 5 6 7 8 9 10

23. How would you rate your outlook for your future? 10 being the best. (circle)

1 2 3 4 5 6 7 8 9 10

24. How would you rate yourself on dependability? 10 being the best. (circle)

1 2 3 4 5 6 7 8 9 10

25. Have there been any major changes in your family situation recently (divorce, moving, etc.)?
Yes No

If yes, please explain.

IMPORTANT: When speaking to a youth who may have had thoughts of hurting themselves or others, it's important to approach the conversation with care, empathy, and non-judgment.

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PARENT/GUARDIAN QUESTIONNAIRE (BASIC)

Basic Information: **Today's Date:** _________ Time: ______

- **Your Name:** ____
- **Your address (where you live):** ____
- **Your Date of Birth:** _________________________
- **Name of child:** ____
- **Your Phone #:** ____

1. Give details about why you are here today?

____

____

2. Were other people involved in your child's situation? Friends? Family?
If 'yes' please provide details: ____

____

____

3. Was anyone in your family disappointed by your child's actions? Yes No
If 'yes', who was disappointed and how did you know they were disappointed? What did they say or do?

____

____

4. Emotionally, describe how much this incident has cost you? (fear, anxiety, sleep loss, etc.)

____

____

5. Describe how this incident has changed your child's life. You can put down something positive or negative.

____

____

6. If your child could do it all over again, what should they have done differently?

____

____

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PARENT/GUARDIAN QUESTIONNAIRE (BASIC)

Page Two

7. List two positive changes you want your child to make:

____

____

8. What are the reasons you want your child to make these positive changes?

____

____

9. What are the steps you plan on taking to help your child make these changes?

____

____

10. List 2 things or people that will get in the way of your child's changes?

____

____

11. What do you plan to do if your plan isn't working?

____

____

12. On a scale of 1 to 10, how bad does your child feel about this situation?

1-2	3-5	6-8	9-10
Doesn't feel bad	Feels a little bad	Feels bad	Feels really bad

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Parent/Guardian Advanced Early Identification Questionnaire

1. Has your child ever been in trouble with the law before? (circle one) Yes No I don't know

If 'yes', please give details:

____

____

2. Does your child often feel sad, hopeless, or irritable? (circle one)

I don't know
Never
Sometimes
Frequently

3. Does your child have difficulty concentrating at school or completing assignments? (circle one)

I don't know
No
Occasionally
Often

4. Does your child have a good group of friends at school they connect with? Yes No I don't know
If yes, please describe.

5. Is your child failing any classes at school? Yes No I don't know
If yes, please explain.

6. Does your child plan on graduating high school: Yes No I don't know
If 'no', please explain.

7. Does your child participate in any extra-curricular school activities? Yes No I don't know
If 'yes', what kind of activities are you involved in?

8. Has your child experienced any major changes in their sleep (sleeping too much or too little)?

Yes No I don't know
If 'yes', why do you think they are having issues with their sleep?

____

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Parent/Guardian Advanced Early Identification Questionnaire - Page Two

9. Has your child lost interest in activities they used to enjoy? Yes No
If yes, why do you think?
____

10. Does your child often feel anxious, worried, or overwhelmed by stress? (circle one)
I don't know
No
Sometimes
Frequently

11. What things or people make your child feel anxious, worried, or overwhelmed?
____
____

12. Lately, has your child experienced panic attacks? (feeling very scared or anxious all of a sudden)

Yes No I don't know
If 'yes', please describe: ____
____

13. Has your child been through any difficult or traumatic experiences recently? Yes No I don't know
(for example: the loss of a loved one, being abused, being bullied)
If yes, please describe: ____
____

14. Has your child expressed wanting to hurting themselves? Yes No I don't know
If yes, please describe: ____
____

15. Has your child expressed wanting to hurt others? Yes No I don't know
If yes, please describe: ____
____

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Parent/Guardian Advanced Early Identification Questionnaire - Page Three

16. How many times per week does your child get really angry? (circle one)
    - Never
    - Occasionally (1 – 3 times per month)
    - Regularly (1-2 times a week)
    - Frequently (more than 2 times a week)

17. Has your child ever used any drugs (including marijuana, tobacco, nicotine/vape, or prescription medications not prescribed to them)? Yes No I don't know

    If yes, how often? (circle one)
    - Occasionally (1–3 times a month)
    - Regularly (1–2 times a week)
    - Frequently (more than 2 times a week)

18. Has your child ever consumed alcohol (including beer, wine, or liquor)? Yes No I don't know

    If yes, how often? (circle one)
    - Occasionally (1 – 3 times a month)
    - Regularly (1 – 2 times a week)
    - Frequently (more than 2 times a week)

19. Do you suspect your child may use drugs or alcohol to cope with stress, anxiety, or sadness? Yes No

20. Has your child ever gotten into trouble (at school or with the law) because of alcohol or drug use?

    Yes No I don't know

21. Do you suspect you may have family members who are currently struggling with substance abuse or mental health issues? Yes No

    If yes, please explain.

22. How would you rate your home environment? 10 being the best. (circle)

    1 2 3 4 5 6 7 8 9 10

23. How would you rate your child's outlook on their future? 10 being the best. (circle)

    1 2 3 4 5 6 7 8 9 10

24. How would you rate your child on being dependable? 10 being the best. (circle)

    1 2 3 4 5 6 7 8 9 10

25. Have there been any major changes in your family situation recently? (divorce, moving, etc.)

    Yes No

    If yes, please explain.

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