Survey 3: Survey of child and youth clients

Client demographics

1. Client’s Gender:
   - □ Male
   - □ Female
   - □ Transgender

2. Client’s Age: ___________________

3. Ethnicity as identified by the client and/or the parent(s) or caregiver(s):
   - □ White
   - □ Chinese
   - □ Black
   - □ Filipino
   - □ Latin American
   - □ South Asian (e.g., East Indian, Pakistan, Sri Lankan, etc.)
   - □ Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese, etc.)
   - □ West Asian (e.g., Afghan, Iranian, etc.)
   - □ Arab
   - □ Japanese
   - □ Korean
   - □ Aboriginal Peoples of North America (North American Indian, Métis, Inuit)
   - □ Other (please specify):___________________________________________

4. Client’s language spoken at home:
   - □ English
   - □ French
   - □ Other (please specify):___________________________________________
5.1. Was the client born in Canada or did the client move to Canada?

☐ Born in Canada
☐ Not born in Canada, and has lived here for __________ years

5.2. Under what status did the client move to Canada?

☐ Immigrant
☐ Refugee
☐ Unknown

6. Sexual orientation as reported by the identified client, if known:

☐ Heterosexual
☐ Gay/lesbian
☐ Bisexual
☐ Unknown

7. What is the client’s current family structure?

☐ Two married parents
☐ Two parents living common law
☐ Single parent
☐ Blended family (e.g., step-parents, step-siblings)
☐ Extended family as caregivers (e.g., grandparents, uncles, aunts, etc.)
☐ Adult siblings as caregivers
☐ Other (please specify): ________________________________

8. Client’s living arrangements:

☐ Single residence
☐ Multiple residences
☐ Foster care
☐ Group home
☐ Homeless or shelter
☐ Other (please specify) ________________________________
9. 1. Does the identified client attend school regularly?

☐ Yes
☐ No (Skip to 12)
☐ Unknown (Skip to 12)
☐ Not applicable, client is not school-aged (Skip to 13)

9.2. What school grade is the identified client in? ____________

10. What type of school does the identified client attend?

☐ Publicly funded school
☐ Privately funded school
☐ Client is home-schooled

11. Does the client attend special programs or classes for any of the following? (Check all that apply)

☐ Learning disorder
☐ Developmental disability
☐ Behaviour
☐ Slow learner
☐ Gifted
☐ Other (please specify): ________________________
☐ None

12. Has the identified client ever been held back a grade?

☐ Yes
☐ No
☐ Unknown
13. (1) Does the client have paid work in any capacity?

☐ Full-time
☐ Part-time
☐ No (Skip to 14)
☐ Unknown (Skip to 14)
☐ Not applicable (Skip to 14)

13. (2) If the client works, what does s/he do?

____________________________________________________________________
____________________________________________________________________

14. Client resides in:

☐ Major urban centre
☐ Suburb of major urban centre
☐ Smaller city or town
☐ Rural setting
**Client service characteristics**

15. Language in which service is provided to client:

   □ English  
   □ French  
   □ Other *(please specify)*:  
   ______________________________________

16. What service(s) did you provide to the client during this session? *(Check all that apply)*

   □ Assessment  
   □ Treatment  
   □ Consultation

17. Please specify and briefly describe the type of assessment, therapy, and/or consultation you provided:

   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________

18. Including today’s session, how many THERAPY sessions have you had related to the identified client? *(Include sessions with parents, teachers, etc.)* ____________

19. Including today’s session, how many ASSESSMENT sessions have you had related to the identified client? *(Include sessions with parents, teachers, etc.)* ____________

20. Including today’s session, how many CONSULTATION sessions have you had related to the identified client? *(Include sessions with parents, teachers, etc.)* ____________
21. How many more sessions of all types do you anticipate providing to or about the identified client? (Include sessions with parents, teachers, etc.)

____________

22. Over all sessions to date, did you consult anyone from the school system in relation to the treatment of the identified client? (Check all that apply)

☐ Teacher(s)
☐ Educational Assistant
☐ Other psychologist
☐ Principal or Vice-principal
☐ Other (please specify): _____________________
☐ No
☐ Not applicable, client is not school-aged

23. Over all sessions to date, who are you seeing connected with the treatment of the identified client (apart from the client his/herself)? (Check all that apply)

☐ Parent(s)
☐ Other family member(s)
☐ Family physician
☐ Other (please specify): _____________________

24. (1) In this session, did you only see the identified client?

☐ Yes
☐ No
24.2. In this session, who else was included in the delivery of the service? (Check all that apply)

- Parent(s)
- Other family member(s) other than caregivers
- Other caregiver(s)
- Other service provider(s)
- Other (please specify): ________________________________

25. Is this client receiving services from another regulated healthcare provider for the same presenting problem?

- Yes
- No

25.2. From whom are they receiving these services?

- Psychiatrist
- Family practitioner or general physician
- Nurse practitioner
- Psychologist
- Counsellor
- Social worker
- Speech language pathologist
- Occupational therapist
- Social service agencies
- Physiotherapist
- Other (please specify): ________________________________

26.1. Is the client or caregiver receiving or participating in community services or support related to the client’s presenting problem?

- Yes
- No
26.2. What type of community service or support?

☐ Big Brother/Big Sister
☐ Therapy camps
☐ Support groups (e.g., bereavement, divorce)
☐ Social skills
☐ Assertive Community Treatment team
☐ Parenting training
☐ Community resource or health centre
☐ Other *(please specify)*: __________________________

27. How was the client referred to you?

☐ Self
☐ Parent(s)
☐ Other client
☐ Legal system
☐ Family member
☐ School system
☐ Psychologist
☐ Psychiatrist
☐ Physician
☐ Other health care professional
☐ Insurance system
☐ Community service
☐ Social services (e.g., CAS)
☐ Professional referral service

28. Have you made any referrals for this client or related to this client for: *(check all that apply)*

☐ Substance abuse
☐ Other mental health
☐ Psychological assessment (neuropsychological, educational, vocational)
☐ Educational (e.g., tutoring)
☐ Parent training or support
☐ Activities of daily living
□ Housing
□ Child and family services
□ Social services other than child and family services
□ Medication
□ Other health (e.g., speech language, occupational therapy)
□ Support or self help
□ Other (*please specify*): ______________________________________
□ No referrals made

29. Service setting is in:

□ Major urban centre
□ Suburb of major urban centre
□ Smaller city or town
□ Rural setting

30. In what type of setting or organization did you provide the service to this client?

□ Private practice setting – group practice
□ Private practice setting – individual practice
□ Public health care organization (e.g. hospital, clinic)
□ Detention centre
□ Community program
□ Child welfare agency
□ School

31. How did the client or the client’s caregiver pay for the service?

□ Paid for services directly, with no extended health insurance reimbursement
□ Paid for services directly, some of which is reimbursed by extended health insurance
□ Paid for services directly, all or most of which is reimbursed by extended health insurance
□ Received services within a publicly funded institution (e.g., hospital, school, correctional facility)
□ Received services paid in part by a publicly funded agency
□ Received services paid in whole by a publicly funded agency
□ Received pro-bono services
□ Other (please specify):________________________________________

32. Briefly, what are the top 3 factors that challenged you in providing or ensuring the best possible service for this particular client? (e.g., lack of specialized services in the community, lack of funding for a needed service, lack of collaboration among partners in care, lack of support from parents or others involved in child’s care)

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

Client psychosocial functioning

33. Does the client have any identifiable risk factors for mental health problems? (Check all that apply)

□ Parental mental disorder and/or family history of mental health problem
□ Physical disability and/or long-term illness in the family
□ Marital problems in the family (e.g., separation, divorce, family instability)
□ Bereavement
□ Mobility (e.g., frequent moves)
□ Physical and/or sexual abuse
□ Removal from family by child welfare authorities; multiple placements
□ Attachment difficulties
□ Bullying
□ Aggression and/or anger
□ Unusual fears, phobias
□ Academic performance problems
□ School avoidance, truancy
□ Pre-term birth
□ Congenital health problems (including genetic conditions)
□ Other health problems
□ Exposure to traumatic events
□ Brain injury (developmental or acquired)
□ Other (please specify): ________________________________
□ Unknown
□ No risk factors

34. What are the reasons for which the client is seeking services or was brought for services? (Check as many that apply):

□ Mood problems or disorders
□ Anxiety problems or disorders
□ Behaviour problems or disorders
□ Intrapersonal issues (e.g., self-esteem, self-confidence, anger, shyness)
□ Attentional problems or disorders (e.g., ADD, ADHD)
□ Learning problems or disorders
□ Gifted assessment
□ School readiness
□ Attachment problems or disorders
□ Cognitive problems other than learning (including developmental delays)
□ Autism spectrum disorders
□ Self-harm behaviours (e.g., suicidal gestures or thoughts, self-injury)
□ Psychosis
□ Managing health, injury, and illness
□ Adjustment to life stressors
□ Parental separation or divorce
□ Adoption consultation
□ Eating disorders
□ Sleep problems or disorders
□ Somatoform disorders (e.g., chronic pain)
□ Sexual abuse and trauma
□ Physical abuse and trauma
□ Psychosexual problems
□ Substance use and/or abuse disorders
□ Other (please specify): ________________________________
35. (1) Does your client have any DSM-IV diagnoses?
   - Yes
   - No
   - Diagnostic evaluation not yet completed
   - Unknown
   - I do not use the DSM

35. (2) If you do not use the DSM, do you make diagnoses using a different classification? (e.g., ICD-10)
   - Yes, please specify:
     ____________________________________________
   - No

35. (3) Enter the names of the client’s diagnoses: (Click here for DSM-IV Diagnostic Names )
   Primary Diagnosis:________________________________________
   Additional Diagnosis:________________________________________
   Additional Diagnosis:________________________________________
   Additional Diagnosis:________________________________________

36. Please rate the extent to which you believe, prior to seeing you, the client’s daily functioning was negatively affected by his or her presenting problem(s):
   - None
   - Little
   - Moderately
   - Severely
   - Unknown
37. Thus far in your work with this client how much change has there been in his or her presenting problem(s)?

☐ Recovered  
☐ Greatly improved  
☐ Improved  
☐ No change  
☐ Deterioration  
☐ Not applicable

38. (1) Does the client report problems related to a chronic disease, disorder or condition, but that is not the presenting problem?

☐ Yes  
☐ No  
☐ Unknown

38.2. What functions are involved in the client’s chronic disorder(s)?

(Check all that apply)

☐ Neurological functions  
☐ Mental functions  
☐ Gross and fine motor functions  
☐ Visual functions  
☐ Auditory functions  
☐ Speech and language functions  
☐ Gastrointestinal functions  
☐ Endocrinological functions  
☐ Cardiological functions  
☐ Respiratory functions  
☐ Immunological functions  
☐ Other (please specify)
39. Please rate the extent to which you believe the client’s daily functioning is restricted by his or her chronic disease(s), disorder(s) or conditions:

□ None
□ Little
□ Moderate
□ Severe
□ Unknown

40. Please rate the extent to which you believe the client’s chronic disease(s), disorder(s), or condition(s) impacts the family:

□ None
□ Little
□ Moderate
□ Severe
□ Unknown

41. Client’s or parents’ appraisal of client’s health status:

□ Excellent
□ Very Good
□ Good
□ Fair
□ Poor
□ Unknown

42. Does your client have a substance use problem or disorder which is not the presenting problem but is concomitant with it?

□ Yes
□ No
□ Unknown
43.1. Is the client receiving psychotropic medication for a *mental health problem*?

- □ Yes
- □ No (skip to 35)
- □ Unknown (skip to 35)

43.2. If yes, what medication(s)? *(Check all that apply)*

- □ Antidepressant
- □ Anxiolytic
- □ Antipsychotic
- □ Stimulant
- □ Hypnotic
- □ Mood Stabilizer
- □ Unknown
- □ Other *(please specify)*: ________________________

43.3. If yes, this medication is prescribed to the client by:

- □ Family physician or general practitioner
- □ Paediatrician
- □ Other specialist physician
- □ Psychiatrist
- □ Nurse-practitioner
- □ Other health specialist

44. Does your client take medication for a *health problem* which is related to the presenting problem? *(e.g., receiving services related to the diagnosis of ADHD and taking Ritalin)*

- □ Yes
- □ No
- □ Unknown
45. Does your client take medication for another health problem *unrelated* to the presenting problem? (e.g., receiving services related to a learning problem but the client also takes insulin for diabetes)

☐ Yes
☐ No
☐ Unknown