

**YPI
Indicated Prevention Screening Form**

PERSONAL INFORMATION

Participant Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City/State/Zip Code:	
Phone:		Colonia Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
D.O.B.	Age:	Race/Ethnicity:	
Grade:	School:	Today's Date:	

SCHOOL DOMAIN

1. On a scale of 1-10, how important is school to you?		Not <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 Very	
2. What do you like best about school?			
3. Is there an adult at school that you think cares about you?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, who?
4. Do you participate in any extracurricular activities in or out of school?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
5. How are your grades?			
6. Have you ever repeated a grade?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, which grade?
7. Have you skipped class or been tardy to class more than three times?			<input type="checkbox"/> Skipped <input type="checkbox"/> Tardy <input type="checkbox"/> No
8. Have you ever been suspended?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
9. Have you had discipline actions in school?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
10. Have you been diagnosed with a learning disability?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
11. Are you experiencing any type of academic problems in school? (For example: writing, reading, core subjects, etc.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?

PEER DOMAIN

1. What do you and your friends do for fun?			
2. If in trouble, do you have a friend who can give you good/healthy advice?			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. On a scale of 1-10, how important is school to your friends?		Not <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 Very	
4. Do your friends do well in school?			<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do your friends participate in any extracurricular activities in or out of school?			<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do your friends use alcohol, tobacco, prescription/over the counter, or other drugs?			<input type="checkbox"/> All <input type="checkbox"/> Most <input type="checkbox"/> Some <input type="checkbox"/> None
7. Do you spend more time with friends who don't use these substances than friends that do?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> About the Same
8. How easy is it for your friends to obtain these substances?		<input type="checkbox"/> Easy <input type="checkbox"/> Somewhat Easy <input type="checkbox"/> Difficult <input type="checkbox"/> Very Difficult	

COMMUNITY DOMAIN

1. Is there an adult in your life that you view as a positive role model?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, who?
2. Do you attend religious services?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. How would you describe your neighborhood? (Ex: Safe, Quiet, Loud, Unsafe, Etc.)			
4. Are you currently experiencing any problems or issues that have not been addressed? (Ex: bullying, Family, Social, School)			
5. Are there gangs in your neighborhood?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, are you involved with them? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you know anyone who is involved with, or a member of, a gang?			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. How many people in your community use alcohol, tobacco, prescription/over the counter, or other drugs?			<input type="checkbox"/> All <input type="checkbox"/> Most <input type="checkbox"/> Some <input type="checkbox"/> None
8. If you wanted to get these substances where would it come from?		<input type="checkbox"/> Friends <input type="checkbox"/> Home/Family <input type="checkbox"/> Store Bought <input type="checkbox"/> Others in the Community	

FAMILY DOMAIN

1. Who do you live with?	
2. Does your family have a history of substance abuse or addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
3. Has anyone in your family been arrested or currently in jail/prison?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you feel like you have a good/healthy relationship with your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No

INDIVIDUAL DOMAIN

1. Do you have children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Expectant Father/Mother?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently in a relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have any health conditions that you are concerned about?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have no legal history.

***If box above is checked, please cross out the following questions 1-6 and continue to the section on drug use.**

1. Have you ever been truant from school?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Have you ever received a school citation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?	
3. Have you ever been arrested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?	
4. Do you have any pending legal charges?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?	
5. Have you been placed on:	<input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> Deferred Probation	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?
6. Have you ever received an MIP or other tickets? (Not including traffic tickets.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for what?	

I have never used Alcohol, Tobacco, Prescription/Over the Counter, or Other Drugs.

***If box above is checked, please cross out the following sections and continue to Referral Information.**

1. Have you ever had seizures after using a drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Have you ever had "withdrawal" symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Have you ever blacked out or passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Have you ever taken a medication not prescribed to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Are you now, or have you ever been, treated for substance abuse/chemical dependency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when and where?	

What is/was your first drug of choice?

1. Age of first use:	
2. How often have you used in the last six months?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Weekends <input type="checkbox"/> Monthly <input type="checkbox"/> Other
3. When was the last time you used?	
4. Average amount used per use:	
5. How do you use it?	

What is/was your second drug of choice?

1. Age of first use:	
2. How often have you used in the last six months?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Weekends <input type="checkbox"/> Monthly <input type="checkbox"/> Other
3. When was the last time you used?	
4. Average amount used per use:	
5. How do you use it?	

REFERRAL INFORMATION

Who referred you to the program?	
Why were you referred to the program?	

Participant Signature: _____

Date: _____

Prevention Specialist (Print **AND** Sign): _____

Date: _____