

GAIN-Quick (GAIN-Q)
Version [GVER]: GQ02.05.01 CORE

Site ID [XSITE]:	1000	Local Site ID [XSITEa]:	100
Staff ID [XSID]:	520	Part. ID [XPID]:	55125
Edit Staff ID [XEDSID]:	1007	Edit Date [XEDDT]:	12/20/2002

BK. Background

1. What is the date you are starting this form? (MM/DD/YYYY)

2. What time is it? (Please also circle AM or PM.): 1-AM 2-PM
H H M M

3. What is your full name?

a. JESSICA (First Name) b. K (M.I.) c. LONGFELLOW (Last Name)

4. What is your gender? (Circle one.) Male 1

Female 2

5. Which race, races or ethnicity best describes you?
(Circle Yes or No for each.)

	<u>Yes</u>	<u>No</u>
a. Alaskan Native	1	<input type="radio"/> 0
b. Asian	1	<input type="radio"/> 0
c. African American/Black	<input checked="" type="radio"/> 1	0
d. Caucasian/White	<input checked="" type="radio"/> 1	0
e. Hispanic, Latino or Chicano	<input checked="" type="radio"/> 1	0
f. Native American	1	<input type="radio"/> 0
g. Native Hawaiian	1	<input type="radio"/> 0
h. Pacific Islander	1	<input type="radio"/> 0
j. Some other group	1	<input type="radio"/> 0

(Please describe. v. _____)

6. What is your date of birth?
(MM/DD/YYYY)

a. How old are you today? Age

[IF 18 OR OVER,
GO TO BK7.]

b. Who has custody of you? (Record a relationship, not a name.)
v. MOTHER

7. What is the highest grade of education you have completed?
Grade

[IF 13 OR HIGHER,
GO TO BK8.]

a. Do you have a high school degree or G.E.D. (General
Equivalency Diploma)? Yes No

8. Have you ever completed this questionnaire before? Yes No

[IF NO, GO TO
GF1a.]

a. About when did you last complete it?
(MM/DD/YYYY)

GF. General Factors

GLPI/ GFI	1. <u>In your lifetime</u> , have you . . .	<u>Yes</u>	<u>No</u>
	a. been treated <u>5 or more times</u> in a hospital or emergency room for physical health problems?.....	1	<input type="text" value="0"/>
	b. <u>ever</u> received treatment or counseling for a mental, emotional, behavioral or psychological problem?.....	1	<input type="text" value="0"/>
	c. <u>ever</u> received treatment or counseling for alcohol, marijuana or other drugs?.....	1	<input type="text" value="0"/>
	d. been stopped by the police or arrested <u>5 or more times</u> ?.....	<input type="text" value="1"/>	0
	2. <u>During the past 12 months</u> , have you . . .		
	a. gotten bad grades or had your grades drop at school or training?.....	<input type="text" value="1"/>	0
	b. been absent 5 or more days from school or training for any reason?.....	<input type="text" value="1"/>	0
	c. skipped or cut school or training just because you didn't want to be there?.....	<input type="text" value="1"/>	0
	d. been suspended or expelled from school or training?.....	<input type="text" value="1"/>	0
	e. done badly at work or done worse at work?.....	1	<input type="text" value="0"/>
	f. been absent 5 or more days from work for any reason?.....	1	<input type="text" value="0"/>
	g. skipped or cut work because you didn't want to be there?.....	1	<input type="text" value="0"/>
	h. been fired, laid off or told not to come in to work?.....	1	<input type="text" value="0"/>
	j. been attacked by someone else?.....	<input type="text" value="1"/>	0
	k. attacked someone else?.....	<input type="text" value="1"/>	0
	m. been arrested?.....	<input type="text" value="1"/>	0
	n. been on probation, parole, or other kinds of court supervision?.....	<input type="text" value="1"/>	0
	3. <u>During the past 90 days</u> , on how many <u>days</u> . . .		<u>Days</u>
	(Use "0" for None or Not Applicable.)		
	a. did you go to any kind of <u>school or training</u> program?.....		<input type="text" value="70"/>
	b. did you <u>miss</u> school or training for any reason?.....		<input type="text" value="20"/>
	c. did you <u>get in trouble</u> at school or training for any reason?.....		<input type="text" value="5"/>
	d. did you go to <u>work</u> ?.....		<input type="text" value="0"/>
	e. did you <u>miss</u> work for any reason?.....		<input type="text" value="0"/>
	f. did you <u>get in trouble</u> at work for any reason?.....		<input type="text" value="0"/>
	g. have you gotten into trouble at home or with your family for any reason?.....		<input type="text" value="60"/>
	h. were you in foster care, a group home or a ward of the state?.....		<input type="text" value="0"/>
	j. have you lived in a place where you were not free to come and go as you please-such as jail, an inpatient program, or hospital?.....		<input type="text" value="0"/>

SS. Sources of Stress

GLPI/
SOSI

1. During the past 12 months, have you been under stress for any of the following reasons related to your family, friends, classmates or co-workers?
- | | <u>Yes</u> | <u>No</u> |
|------------------------------------------------------------------------|----------------------------|----------------------------|
| a. Birth or adoption of a new family member | 1 | <input type="checkbox"/> 0 |
| b. Health problem of a family member or close friend | <input type="checkbox"/> 1 | 0 |
| c. Major change in relationships (marriage, divorce, separation) | <input type="checkbox"/> 1 | 0 |
| d. Death of a family member or close friend | <input type="checkbox"/> 1 | 0 |
| e. Fights with boss/teacher or co-workers/classmates | <input type="checkbox"/> 1 | 0 |
| f. Other changes or problems in primary support groups | <input type="checkbox"/> 1 | 0 |
| (Please describe. v. <u>MOM'S BOYFRIEND MOVED IN</u>) | | |
2. During the past 12 months, have you been under stress because of the following other kinds of demands on you?
- | | | |
|---------------------------------------------------------------------------|----------------------------|----------------------------|
| a. Major change in housing or bad housing | 1 | <input type="checkbox"/> 0 |
| b. New job, position, or school | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 |
| c. Hard work or school schedule | <input type="checkbox"/> 1 | 0 |
| d. Problems with transportation | 1 | <input type="checkbox"/> 0 |
| e. Discrimination in community, work, school, or transportation | 1 | <input type="checkbox"/> 0 |
| f. Threat of losing current housing, job, school, or transportation | 1 | <input type="checkbox"/> 0 |
| g. Interruption or loss of housing, job, school, or transportation | <input type="checkbox"/> 1 | <input type="checkbox"/> 0 |
| h. Something you saw or that happened to someone close to you | <input type="checkbox"/> 1 | 0 |
| (Please describe. v. <u>FRIEND PUSHED DOWN STAIRS</u>) | | |
| j. Other environmental demands on you | 1 | <input type="checkbox"/> 0 |
| (Please describe. v. _____) | | |
3. During the past 12 months, were you attacked with a weapon, beaten, sexually abused or emotionally abused?
- | | | |
|--|----------------------------|---|
| | <input type="checkbox"/> 1 | 0 |
|--|----------------------------|---|
4. Are you currently worried that someone might . . .
- | | | |
|----------------------------------------------------------------------------------------|----------------------------|----------------------------|
| a. <u>attack</u> you with a gun, knife, stick, bottle, or other weapon? | <input type="checkbox"/> 1 | 0 |
| b. <u>hurt you by striking or beating</u> or otherwise physically abusing you? | <input type="checkbox"/> 1 | 0 |
| c. pressure or <u>force you to participate in sexual acts</u> against your will? | 1 | <input type="checkbox"/> 0 |
| d. <u>abuse you emotionally</u> ? | <input type="checkbox"/> 1 | 0 |

PH. Physical Health

GLPI/
HDI

1. During the past 12 months, would you say your health in general was...?

(Circle one.)

- Excellent..... 0
- Very good.....
- Good..... 2
- Fair..... 3
- Poor..... 4

2. During the past 12 months, has your health limited your ability to do . . .

Yes No

- a. vigorous activities like running, lifting heavy objects or active sports?..... 1
- b. moderate activities like moving a table, carrying groceries or light sports?..... 1
- c. light activities like bending, lifting or stooping? 1

3. During the past 12 months, have you . . .

- a. lost or gained 10 or more pounds when you were not trying to? ... 1
- b. had a lot of physical pain or discomfort?..... 1
- c. been worried about your health or behaviors?..... 1
- d. had health problems that kept you from meeting your responsibilities at work, school or home? 1
- e. had lung or breathing problems?..... 1
- f. had pain when you urinated? 1
- g. coughed up or urinated blood? 1

4. During the past 90 days, on how many days . . .

Days

- a. were you bothered by any health or medical problems?.....
- b. did you have medical problems that kept you from meeting your responsibilities at work, school or home?.....
- c. have you gone without eating (or threw up much of what you did eat?).....

EH. Emotional Health

The next questions are about common psychological problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities or they make you feel like you cannot go on.

IBS/ DSS-5	1.	<u>During the past 12 months</u> , have you had <u>significant</u> problems with. . . <u>Yes</u> <u>No</u>	
	a.	headaches, faintness, dizziness, tingling, numbness, sweating or hot or cold spells?.....	1 <input style="width: 30px; text-align: center;" type="text" value="0"/>
	b.	sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	c.	feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	d.	having no energy and losing interest in work, school, friends, sex or other things you cared about?.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	e.	remembering, concentrating, making decisions, or having your mind go blank?.....	1 <input style="width: 30px; text-align: center;" type="text" value="0"/>
IBS/ SRS-5	2.	<u>During the past 12 months</u> , have you. . .	
	a.	thought about killing or hurting someone else?.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	b.	thought about ending your life or committing suicide?.....	1 <input style="width: 30px; text-align: center;" type="text" value="0"/> [IF NO, GO TO 3a.]
	c.	had a plan to commit suicide?.....	1 0
	d.	gotten a gun, pills or other things to carry out your plan?.....	1 0
	e.	attempted to commit suicide?.....	1 0
IBS/ ATS-7	3.	<u>During the past 12 months</u> , have you had <u>significant</u> problems with. . .	
	a.	feeling very anxious, nervous, tense, fearful, scared, panicked or like something bad was going to happen?.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	b.	having to repeat an action over and over, or having thoughts that kept running over in your mind?.....	1 <input style="width: 30px; text-align: center;" type="text" value="0"/>
	c.	trembling, having your heart race or feeling so restless that you could not sit still?.....	1 <input style="width: 30px; text-align: center;" type="text" value="0"/>
	4.	<u>During the past 12 months</u> , have the following situations happened to you?	
	a.	When something reminded you of the past, you became very distressed and upset.	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	b.	Sometimes you used alcohol or other drugs to help yourself sleep or forget about things that happened in the past.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	c.	You had a hard time expressing your feelings, even to the people you cared about.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	d.	You felt guilty about things that happened because you felt like you should have done something to prevent them.....	<input style="width: 30px; text-align: center;" type="text" value="1"/> 0
	5.	<u>During the past 90 days</u> , on how many <u>days</u> were you... <u>Days</u>	
	a.	bothered by any nerve, mental, or psychological problems?.....	<input style="width: 60px; text-align: center;" type="text" value="30"/>
	b.	disturbed by memories of things from the past that you did, saw or had happen to you?.....	<input style="width: 60px; text-align: center;" type="text" value="90"/>

BH. Behavioral Health

EBS/ AIS-6	1. <u>During the past 12 months</u> , have you done the following things <u>two or more times</u> ?	<u>Yes</u>	<u>No</u>
	a. Had a hard time paying attention at school, work or home.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	b. Had a hard time listening to instructions at school, work or home.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	c. Had a hard time staying organized or getting everything done.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	d. Been unable to stay in a seat or where you were supposed to stay.....	1	<input type="checkbox"/> 0
	e. Gotten in trouble for being too "loud" when you were playing or relaxing.....	1	<input type="checkbox"/> 0
	f. Had a hard time waiting for your turn.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
EBS/ BPS-6	2. <u>During the past 12 months</u> , have you done the following things <u>two or more times</u> ?		
	a. Been a bully or threatened other people.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	b. Lied or conned to get things you wanted or to avoid having to do something.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	c. Stayed out at night later than your parent or partner wanted.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	3. <u>During the past 12 months</u> , have you had a disagreement in which <u>you</u> did the following things?		
	a. Insulted or swore (cursed) at someone.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	b. Pushed, grabbed, or shoved someone.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	c. Kicked, bit, or hit someone.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
EBS/ GCS-4	4. <u>During the past 12 months</u> , have you. . .		
	a. purposely damaged or destroyed property that did not belong to you?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	b. other than from a store, taken money or property that didn't belong to you?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	c. hit someone or gotten into a physical fight?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0
	d. sold, distributed or helped to make illegal drugs?.....	1	<input type="checkbox"/> 0
	5. <u>During the past 90 days</u> , on how many <u>days</u> did you. . . (Use "0" for None or Not Applicable.)		<u>Days</u>
	a. have any problems paying attention, controlling your behavior or breaking rules you were supposed to follow?	<input type="text" value="90"/>	
	b. have an argument with someone else in which you swore (cursed), threw something, or threatened, pushed or hit someone?	<input type="text" value="45"/>	
	c. do things that might get you in trouble or be against the law besides using (alcohol or) drugs?.....	<input type="text" value="90"/>	
	d. spend time on probation or parole?.....	<input type="text" value="10"/>	
	e. spend time under electronic monitoring or house arrest?	<input type="text" value="0"/>	
	f. spend time in jail or detention?	<input type="text" value="0"/>	
	6. <u>During the past 90 days</u> , how many <u>times</u> did you get arrested, booked and charged with a crime? (Use "0" for None.)	<input type="text" value="1"/>	Times

SR. Substance-Related Issues

		Yes	No	
SPS/ SUAS-9	1. <u>During the past 12 months</u> , have you used any alcohol, marijuana, cocaine, heroin, or other substances?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	[IF NO, GO TO SR5.]
	<u>During the past 12 months</u> . . .			
	1a. have you tried to hide that you were using alcohol, marijuana or other drugs?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	b. have your parents, family, partner, co-workers, classmates or friends complained about your alcohol, marijuana or other drug use?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	c. have you used alcohol, marijuana or other drugs weekly?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	d. has alcohol, marijuana or other drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual desire or caused other psychological problems?	1	<input type="checkbox"/> 0	
	e. has alcohol, marijuana or other drug use caused you to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease or any other health problems?	1	<input type="checkbox"/> 0	
	2. <u>During the past 12 months</u> . . .			
	a. have you kept using alcohol, marijuana or other drugs even though you knew it was keeping you from meeting your responsibilities at work, school, or home?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	b. have you used alcohol, marijuana or other drugs where it made the situation unsafe or dangerous for you, such as when you were driving a car, using a machine, or where you might have been forced into sex or hurt?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	c. has alcohol, marijuana or other drug use caused you to have repeated problems with the law?	1	<input type="checkbox"/> 0	
	d. have you kept using alcohol, marijuana or other drugs even after you knew it could get you into fights or other kinds of legal trouble?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
SPS/ SDS-7	3. <u>During the past 12 months</u> . . .			
	a. have you needed more alcohol, marijuana or other drugs to get the same high or found that the same amount did not get you as high as it used to?	1	<input type="checkbox"/> 0	
	b. have you had withdrawal problems from alcohol, marijuana or other drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or have you used any alcohol, marijuana or other drugs to stop being sick or avoid withdrawal problems?	1	<input type="checkbox"/> 0	
	c. have you used alcohol, marijuana or other drugs in larger amounts, more often or for a longer time than you meant to?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	d. have you been unable to cut down or stop using alcohol, marijuana or other drugs?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	e. have you spent a lot of time either getting alcohol, marijuana or other drugs, using them, or feeling the effects of them (high, sick)?	1	<input type="checkbox"/> 0	
	f. has alcohol, marijuana or other drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
	g. have you kept using alcohol, marijuana or other drugs even after you knew it was causing or adding to medical, psychological or emotional problems you were having?	1	<input type="checkbox"/> 0	

(If there were days in a controlled environment, use the calendar to identify personal anchors for the last 90 days in the community.)

For the next set of questions, please answer for the last 90 days that you lived in the community. Do not count days when you were living in a jail, hospital, or other place where you could not use alcohol, marijuana, or other drugs.

4. During the last 90 days that you lived in the community, on how many days did you. . . (Use "0" for None.) Days
- | | |
|------------------------------------------------------------------------------------------------------------|----|
| b. drink beer, wine, or any kind of alcohol? | 60 |
| c. get drunk or have 5 or more drinks at one time? | 26 |
| d. smoke or use any kind of marijuana, blunts or hashish? | 40 |
| e. use LSD, cocaine, heroin, ecstasy, inhalants or any other kind of drug?
(What did you use? v. _____) | 0 |
| f. go <u>without using any</u> alcohol, marijuana, or other drugs? | 10 |
5. During the last 90 days that you lived in the community, on how many days did you smoke or use any kind of tobacco?..... 90

SU. Service Utilization
(Please use "0" for None or Not Applicable.)

- | | | | |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--|
| 1. | <u>During the past 90 days</u> , how many <u>times</u> did you go to an <u>emergency room</u> for. . . | <u>Times</u> | |
| | a. physical health problems? | 0 | |
| | b. mental, emotional, behavioral or psychological problems? | 0 | |
| | c. alcohol or drug use problems? | 0 | |
| 2. | <u>During the past 90 days</u> , on how many <u>nights</u> did you stay in a <u>residential, inpatient, or hospital program</u> for. . . | <u>Nights</u> | |
| | a. physical health problems? | 0 | |
| | b. mental, emotional, behavioral or psychological problems? | 0 | |
| | c. alcohol or drug use problems? | 0 | |
| 3. | <u>During the past 90 days</u> , how many <u>times</u> did you go to an <u>outpatient program, clinic or counselor</u> for. . . | <u>Times</u> | |
| | a. physical health problems? | 0 | |
| | b. mental, emotional, behavioral or psychological problems? | 0 | |
| | c. alcohol or drug use problems? | 0 | |
| 4. | <u>During the past 90 days</u> , on how many <u>days</u> did you take <u>medication</u> for. . . | <u>Days</u> | |
| | a. physical health problems? | 0 | |
| | b. mental, emotional, behavioral or psychological problems? | 0 | |
| | c. alcohol or drug use problems? | 0 | |
| 5. | <u>During the past 90 days</u> , on how many <u>days</u> did you see a counselor or other professional about your health, emotional, behavioral, alcohol or drug problems at a. . . | <u>Days</u> | |
| | a. school or student assistance program? | 5 | |
| | b. job or employee assistance program? | 0 | |
| | c. spiritual program or religious organization? | 0 | |

EN. End

1. Do you want help with any family, school, work, health, emotional, behavioral, alcohol, drug, or legal problems?.....

<u>Yes</u>	<u>No</u>
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 0

(If Yes, please describe below.)

- v1. I WANT TO BE ABLE TO TALK W/ MY MOM
 v2. W/OUT GETTING INTO A FIGHT; I DON'T WANT
 v3. TO GET IN TROUBLE W/ THE LAY ANYMORE

- | | | |
|---------------------------------------------------------------------------|---------------------------------------|----------------------------|
| | <u>Yes</u> | <u>No</u> |
| 2. Did anyone read these questions to you or help you fill out this form? | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 0 |
| 3. Is English your first language?..... | <input checked="" type="checkbox"/> 1 | <input type="checkbox"/> 0 |
| a. (If No, what is? v. _____) | | |

4. What kind of place best describes where you completed this form?

(Circle one.)

- | | |
|-----------------------------------------------------------------------|---------------------------------------|
| Home | 1 |
| School or training program | <input checked="" type="checkbox"/> 2 |
| Employment or work setting | 3 |
| Prison, jail, or detention | 4 |
| Probation, parole, or other non-controlled correctional setting | 5 |
| Treatment or intake unit | 6 |
| Research office | 7 |
| Other (Please describe. v. _____) | 99 |

5. What time is it? **(Please also circle AM or PM.):**.....

09:46		<input checked="" type="checkbox"/> 1-AM <input type="checkbox"/> 2-PM
H H		M M

Thank You! Please return this form to the person who gave it to you.

(For further information on this form see www.chestnut.org/li/gain/gain_q.)

CD. Case Disposition - For Staff Use Only

1. Referral Source(s) v. MR. JOHNSON (PRINCIPAL), MR. CARR (PO)

a. b. c. d. e.

2. Issues	1. Reasons for Referral		2. Recommendations	
	Yes	No	Yes	No
a. Random screening	1	<input type="text" value="0"/>		
b. General concern (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
c. Family problems (v. _____)	1	<input type="text" value="0"/>	<input type="text" value="1"/>	0
d. Peer or partner problems (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
e. Grief or other emotional crises (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
f. Spiritual issues (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
g. Race/ethnicity/gender identity issues (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
h. Teenage parenting issues (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
j. Environmental problems (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
k. School problems (v. GRADES ABSENCES FIGHTS W/TEACHER,STUDENT)	<input type="text" value="1"/>	0	<input type="text" value="1"/>	0
m. Physical health problems (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
n. Emotional problems (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
p. Behavioral or conduct problems (v. AGGRESSIVE BEHAVIOR, CUTTING SCHOOL)	<input type="text" value="1"/>	0	<input type="text" value="1"/>	0
q. Gang or illegal activity (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
r. Substance use (v. RECENTLY CAUGHT USING AT SCHOOL)	<input type="text" value="1"/>	0	<input type="text" value="1"/>	0
s. Noncompliance (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
t. Continuing care/support (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>
u. Other (v. _____)	1	<input type="text" value="0"/>	1	<input type="text" value="0"/>

3. Placement(s) v. FAM COUNS, ASSESS, SAP GRP/IND, TUTORING

a. b. c. d. e.

4. Additional Comments:
NEG RELATIONSHIP W/MOM, DIVERSION PROG.