ADOLESCENT QUESTIONNAIRE
Ages 13-18

*****THIS FORM TO BE FILLED OUT BY ADOLESCENT*****

This form will assist your therapist in knowing about you and will be kept confidential. Please complete all seven (8) pages.

Print clearly.

CLIENT DEMOGRAPHICS

Client Name:_____ Date:_____

Birth date: _____/_____/_____ Age:_____ Gender: Female Male

PRESENTING PROBLEM

1. Describe the problems you are having and when they began:

   _____

   _____

   _____

2. What has contributed to this difficulty?

   _____

   _____

   _____

MEDICAL HISTORY

1. List allergies, serious illnesses, surgeries, injuries, hospitalizations:

   _____

   _____

2. List both prescription and over-the-counter medications presently used for physical conditions:

   _____

   _____

3. My over-all general health is: ___Excellent ___Good ___Fair ___Poor

4. What physical illnesses run in your family?

_____

_____

_____

5. What is the name of your Doctor/Pediatrician?

_____

EDUCATIONAL HISTORY

1. What school do you attend? _____ Grade _____
2. Do you have any problems in school? YES NO If yes, please explain:

_____

_____

3. Have you ever repeated or skipped a grade? YES NO Which one? _____

4. Have you ever dropped out, been expelled, or been suspended? _____
   What happened? _____

_____

5. How has your attendance been? ___Excellent ___Good ___Fair ___Poor
   What are your grades like? _____
   Have they changed a lot? YES NO

6. Do you have learning difficulties or attend special classes? YES NO

7. Have you ever had psychological testing? YES NO

8. What are your extra-curricular activities?

_____

_____

OCCUPATION

1. Do you have a job outside of school? Yes No
   Where do you work? _____
   What do you do? _____

LEGAL HISTORY (in regards to child or any family member)

1. Have you or your family members ever been involved with the legal system (criminal, divorce, custody, civil, probation, etc.)? YES NO If so, in what way?

_____

_____

_____

2. Are you or your family members currently involved with the legal system (criminal, divorce, custody, civil, probation, etc.)? YES NO If so, in what way?

_____

_____

_____

3. Do you have any criminal or civil cases pending? YES NO

4. Do you currently have a probation/parole officer? YES NO

   If so, who? _____

5. Do you anticipate any involvement with the legal system in the future? YES NO

TREATMENT HISTORY

1. Have you been in counseling before? YES NO

   If so, with whom? _____

   What was the primary issue?

   _____

   When? _____

   For how long? _____

   What was the outcome? _____

2. Have you ever been hospitalized for emotional problems or for alcohol/drug treatment? YES NO
   If so when? _____ Where? _____

   What was the outcome?_____

3. What medications have you taken in the past for emotional or mental problems?
   _____
   _____

4. What medications are you currently taking for emotional or mental problems?
   _____
   _____

5. Is there a history of mental illness in your family? If so, please explain_____
   _____
   _____

RELATIONSHIPS

1. From whom do you get emotional support?
   _____
2. Do you have friends? YES NO
3. How do you get along with those friends? _____
   _____
4. Has there been a change in your circle of friends lately? YES NO
5. Do your friends tend to get into trouble? YES NO
6. Do you belong to a gang? YES NO
7. Do any of your friends belong to a gang? YES NO
8. What have been the losses, changes, crises, and transitions in your life? _____
   _____
   _____
9. Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences your life? Please explain: _____

10. Is there anything currently going on in your life that it would be important for your therapist to know? _____

_____

_____

FAMILY HISTORY

1. ABOUT YOUR HOUSEHOLD

Name	Age	Relationship to You	How do you get along?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Important people in your life (immediate family/relatives/significant others)

Name	Age	Relationship to You	How do you get along?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Do you live with your parents? YES NO
   Have you ever lived away from your parents? YES NO
   Under what circumstances? _____

4. Do you have any brothers/sisters, step-brothers/sisters, or half-brothers/sisters who do not live with you? YES NO

5. Your experiences while growing up can affect your life. What experiences and events (discipline, favoritism, trauma, affection, lack of attention, etc.) have been important in your life? _____

6. Please list your present and past boyfriend(s)/girlfriend(s).

7. First Name	Time Together	Reason for Ending Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SEXUAL HISTORY

Sex Education: _____Home; _____School; _____Friend

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1. Are you currently sexually active? YES NO
2. Single Partner _____ Multiple Partners ____
   Same Sex Partner _____ Both Sex Partners _____
3. Do you use Condoms? YES NO Do you use Birth Control? YES NO
4. Have you ever been sexually abused? YES NO
   If yes, by whom and for what length of time? _____
   _____
5. Has anyone ever touched you or talked to you sexually in a way that made you uncomfortable? YES NO

CONCERNS

Have you or any of your family members ever experienced any of the following problems:

Concern	Person(s) Who Experienced This
Mental Illness	_____
Depression	_____
Anxiety	_____
Emotional Abuse	_____
Physical Abuse	_____
Sexual Abuse	_____
Alcohol Abuse	_____
Drug Abuse	_____
Other:_____	_____

SUBSTANCE USE

Do you use drugs? YES NO Regularly? Occasionally?

If so, how does your usage affect your life? _____

What drugs have you taken:

_____Depressants: Alcohol, Tranquilizers, Sleeping Pills, Inhalants

_____Stimulants: Ecstasy, Cocaine, Crack, Crank, Speed, Caffeine, Nicotine

_____Narcotics: Heroin, Codeine, Morphine

_____Hallucinogens: LSD/Acid, PCP, Peyote, Shrooms

_____Cannabis: Marijuana_____ Other:_____

When did you first use? _____

When did you last use? _____

SAFETY QUESTIONS?

SUICIDE/HOMICIDE

Have you ever had or do you have? Check all that apply.

	Past	Now
Thoughts of hurting yourself?	_____	_____
Self-harmed (cut, burned, bruised, etc) yourself?	_____	_____
Thoughts of committing suicide?	_____	_____
Plans to commit suicide?	_____	_____
Attempts to commit suicide?	_____	_____
Threats to commit suicide?	_____	_____
Thoughts of harming someone?	_____	_____
Plans to harm someone?	_____	_____
Attempts to harm someone?	_____	_____
Threats to harm someone?	_____	_____
Actually harmed someone?	_____	_____

DEPRESSION

Have you ever or do you now have? Check all that apply.	Past	Now
Inability to sleep or sleeping longer?	_____	_____
Increased or decreased appetite?	_____	_____
Tearfulness or feelings of despair?	_____	_____
Lack of energy or feelings of fatigue?	_____	_____
Preoccupation with life events?	_____	_____
Decreased contact with others?	_____	_____
Feelings of depression?	_____	_____