



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 (7) 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 is the highest **grade you have completed**? _____

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**? Which one? _____

What happened? _____

5. How has your **attendance** been? ___Excellent ___Good ___Fair ___Poor



6. What are your **grades** like? _____ Have they changed a lot? YES NO
7. Do you have **learning difficulties** or attend **special classes**? YES NO
8. Have you ever had **psychological testing**? YES NO
9. What are your **extra-curricular activities**? _____
-

OCCUPATION

1. Where do you **work**? _____ **What** do you do? _____
-

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

1. Have you **ever been involved** with the legal system (criminal, divorce, custody, civil, etc.)? YES NO If so, in what way? _____
-
2. Are you **currently involved** with the legal system (criminal, divorce, custody, civil, 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? _____
2. What was the **primary issue**? _____
When? _____ For how long? _____ What was the outcome? _____
-
3. Have you ever been **hospitalized for emotional problems** or for **alcohol/drug treatment**? YES NO
If so when? _____ Where? _____ What was the outcome? _____
-
4. What **medications** have you taken **in the past** for **emotional or mental problems**? _____
-
5. What medications are you **currently taking** for emotional or mental problems? _____
-
6. Is there a **history of mental illness** in your family? If so, please explain _____
-



SOCIAL HISTORY

1. What are your major **strengths**? _____

2. What are your major **weaknesses**? _____

3. From whom do you get **emotional support**? _____
4. Do you have **friends**? YES NO
5. How do you **get along with** those friends? _____

6. Has there been a **change** in your circle of friends lately? YES NO
7. Do your friends tend to **get into trouble**? YES NO
8. Do you **belong to a gang**? YES NO
9. Do any of your **friends belong to a gang**? YES NO
10. What have been the **losses, changes, crises, and transitions** in your life? _____

11. Do you have a **belief system** (cultural, moral, spiritual, religious, etc.) which influences your life? Please explain:

12. Is there **anything about your lifestyle** (or the family's) that would be **helpful for your counselor to know**?

FAMILY HISTORY

1. ABOUT YOUR HOUSEHOLD

| <u>Name</u> | <u>Age</u> | <u>Relationship to You</u> | <u>How do you get along?</u> |
|-------------|------------|----------------------------|------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

| <u>Name</u> | <u>Age</u> | <u>Relationship to You</u> | <u>How do you get along?</u> |
|-------------|------------|----------------------------|------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |



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)**.

| <u>First Name</u> | <u>Time Together</u> | <u>Reason for Ending Relationship</u> |
|-------------------|----------------------|---------------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

PHYSICAL DEVELOPMENT

1. Please **complete/check** the following:

- | | |
|------------------------------------|----------------------------|
| ____ Height | ____ Underarm hair |
| ____ Weight | ____ Menstruation (female) |
| ____ Build (light, average, heavy) | ____ Voice change (male) |
| ____ Breast development (female) | ____ Beard (male) |
| ____ Genital hair | ____ Acne |

SEXUAL HISTORY

1. **Sex Education:** ____ Home; ____ School; ____ Friends
2. Are you **currently sexually active**? YES NO 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 **had a STD** (Sexually Transmitted Disease)? YES NO
 If so what? _____
5. Have you ever been **sexually abused**? YES NO If yes, **by whom** and for what **length of time**? _____
6. Has anyone ever **touched you or talked to you sexually** in a way that made you uncomfortable? YES NO

CONCERNS

For you or any of the above relationships (household, brothers/sisters, partners), have you or any of those persons **ever experienced any of the following problems**:



| <u>Concern</u> | <u>Person(s) Who Experienced This</u> |
|----------------------|---------------------------------------|
| Mental Illness | _____ |
| Depression | _____ |
| Neglect | _____ |
| Sexual Dysfunction | _____ |
| Financial Difficulty | _____ |
| Emotional Abuse | _____ |
| Physical Abuse | _____ |
| Sexual Abuse | _____ |
| Alcohol Abuse | _____ |
| Drug Abuse | _____ |
| Other: _____ | _____ |

POSSIBLE ISSUES

SUBSTANCE ABUSE Do you use **drugs**? Regularly? Occasionally? **How does your usage affect your life?**

What **drugs have you taken**:

- _____ Depressants: Alcohol, Tranquilizers, Sleeping Pills, Inhalents
- _____ Stimulants: Cocaine, Crack, Crank, Speed, Diet Pills
- _____ Stimulants: 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**? _____

SUICIDE/HOMICIDE

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

| | <u>Past</u> | <u>Now</u> |
|---------------------------------|-------------|------------|
| Thoughts of hurting 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? _____

Decreased interest in pleasurable activities _____

Is there **anything else** that may be **helpful for your counselor to know** that we have not asked?

Child Checklist of Characteristics

Please check all that apply.

| |
|---|
| Accident prone |
| Affectionate |
| Aggressive |
| Argues, "talks back," smart-alecky, defiant |
| Assaults |
| Bathroom language |
| Bigoted |
| Bossy to others |
| Breaks rules |
| Breaks the law |
| Bullied by others |
| Bullies/ intimidates, teases, inflicts pain on others |
| Cheats |
| Clowns around |
| Competition |
| Complains |
| Complains of feeling sick |
| Compliant |
| Concern for others |
| Conflicts at school |
| Conflicts at home with parents over rule breaking, money, chores, choices |
| Conflicts with friends |
| Conflicts with police |
| Cries easily, feelings are easily hurt |
| Cruel to animals |
| Dares others |
| Dawdles, procrastinates, wastes time |
| Daydreams |
| Defiant |
| Dependent, immature |
| Destructive |
| Developmental delays |
| Difficulties with parent's paramour/new marriage |
| Disobedient, uncooperative, refuses, noncompliant |
| Disrupts family activities |
| Distractible, inattentive, poor concentration, daydreams |
| Dropping out of school |
| Drug or alcohol use |
| Drug sales |
| Eating issues, poor manners, over/under eats, refuses |
| Exercise problems |
| Extracurricular activities interfere with academics |
| Failure in school |
| Fantasy life |
| Fearful |
| Feelings are easily hurt |
| Fidgety |
| Fighting, hitting, violent, aggressive, hostile, threatens |
| Finger sucking |
| Fire starting |
| Fire setting |

| |
|---|
| Friendly, outgoing, social |
| Hair chewing, pulling |
| Head banging |
| Hitting |
| Hostile |
| Hyperactive |
| Hypochondriac, always complains of feeling sick |
| Imaginary playmates, fantasy |
| Immature, "clowns around," has only younger playmates |
| Inappropriate sexual behaviors |
| Inattentive |
| Independent |
| Inflicts pain on others |
| Insults others |
| Interrupts, talks out, yells |
| Intimidated by others |
| Intimidates others |
| Intolerant |
| Irritability |
| Isolates |
| Lacks organization, unprepared |
| Lacks respect for authority, insults, dares, provokes |
| Learning disability |
| Legal difficulties, truancy, loitering, vandalism, drinking |
| Lethargic |
| Likes to be alone, withdraws, isolates |
| Loitering |
| Loss of friends |
| Low-frustration tolerance, irritability |
| Lying |
| Manipulates |
| Masturbation |
| Mental retardation |
| Moody |
| Mute – refuses to speak |
| Nail biting |
| Name calling |
| Needs high supervision at home over play/chores/schedule |
| Negativism |
| Nervous |
| New school |
| Nightmares |
| Noisy |
| Noncompliant |
| Obedient |
| Obesity |
| Only younger playmates |
| Oppositional, resists, refuses, does not comply, negativism |
| Outgoing |
| Out-of- seat behaviors |
| Overactive, restless, hyperactive, restlessness, fidgety |
| Picks on others |
| Poor concentration |
| Pouts |
| Prejudiced, bigoted, insulting, name calling, intolerant |

| |
|---|
| Procrastinates |
| Provokes others |
| Rages |
| Recent move, new school, loss of friends |
| Refuses |
| Relationships with friends are poor |
| Relationships with siblings –competition, fights, teasing/provoking |
| Relationships with teachers poor |
| Resists |
| Responsible |
| Restless |
| Rocking motion/behavior |
| Repetitive movements |
| Runs away |
| Sad, unhappy |
| School avoiding |
| Self-harming behaviors—biting, hitting self, scratching |
| Sexual preoccupation, inappropriate sexual behaviors |
| Sexually active |
| Shy, timid |
| Slow moving |
| Slow responding |
| Smart-alecky |
| Smoking |
| Social |
| Speech difficulties |
| Stealing |
| Stubborn |
| Suicide talk or attempt |
| Swearing, blasphemes, bathroom language, fowl language |
| Talks back |
| Teased, picked on, victimized, bullied |
| Teases others |
| Temper-tantrums, rages |
| Threatens |
| Thumb sucking, finger-sucking |
| Tics – involuntary rapid movements, noises or word productions |
| Timid |
| Truancy, school avoiding |
| Uncooperative |
| Uncoordinated, accident-prone |
| Under-active, slow-moving |
| Unhappy |
| Unprepared |
| Vandalism |
| Violent |
| Wastes time |
| Wetting/soiling of bed or clothes |
| Withdraws |
| Yells |

Other:



Thank you for completing this questionnaire.