

ADOLESCENT QUESTIONNAIRE
(To be completed by adolescent, ages 13 – 17.)

NAME: _____ AGE: _____ TODAY'S DATE: _____

Please answer the following questions as honestly and completely as possible.

CURRENT PROBLEM

1. Briefly describe the major problem for which you are seeking help: _____

2. How long have you had this problem? _____
3. What other problems would you like help with? _____

4. Have you ever seen a counselor of any kind before? When? Why? _____

5. What led you to seek help at this time? _____

6. What is the likelihood that you will achieve your goal?
 Not at all likely Slight possibility Good chance Probably Very likely
7. Who else knows that you have this problem? _____

PROBLEM CHECKLIST

Please check each of the items below that you have experienced recently:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> the future looks grim | <input type="checkbox"/> poor social life | <input type="checkbox"/> physical complaints |
| <input type="checkbox"/> confused thoughts | <input type="checkbox"/> feel like harming myself | <input type="checkbox"/> in trouble with the law | <input type="checkbox"/> headaches |
| <input type="checkbox"/> disturbing thoughts | <input type="checkbox"/> tire easily and often | <input type="checkbox"/> act before thinking | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> seeing things that aren't there | <input type="checkbox"/> feel lonely | <input type="checkbox"/> do not assert myself | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> hearing things | <input type="checkbox"/> don't like myself | <input type="checkbox"/> can't get things done | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> trouble with my memory | <input type="checkbox"/> feel useless | <input type="checkbox"/> school problems | <input type="checkbox"/> sexual issues |
| <input type="checkbox"/> distrustful of others | <input type="checkbox"/> anxious and tense | <input type="checkbox"/> family problems | <input type="checkbox"/> feel angry |
| <input type="checkbox"/> unreasonable fears | <input type="checkbox"/> panic attacks | <input type="checkbox"/> relationship problems | <input type="checkbox"/> feel violent |
| <input type="checkbox"/> people don't understand me | <input type="checkbox"/> feel like I have no control | <input type="checkbox"/> aches and pains | <input type="checkbox"/> use of alcohol or drugs |
| <input type="checkbox"/> feel sad and blue | <input type="checkbox"/> other: _____ | | |

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DRUG AND ALCOHOL HISTORY

ADOL Q

1. Do you smoke cigarettes? No Yes # per day: _____ # of years: _____
Do you want to quit? No Yes
2. Do you drink alcohol? No Yes #days per wk: _____ #drinks per wk: _____ # years: _____
3. Do you use street drugs? No Yes Which ones? _____
How often? Experimental Occasional Regularly
4. Have you ever been charged with a crime? No Yes Explain: _____
Convicted? No Yes

FAMILY HISTORY

1. Siblings: # of brothers: _____ # of sisters: _____ Your birth order (i.e., 2nd of 4): _____
2. Parents: Biological: _____ Step: _____
3. Who lives at home with you? _____
4. How do you fit in within your family? _____
5. Does your family have rules to follow (i.e., curfew, respect)? No Yes , and How fair are the rules? _____

EDUCATIONAL HISTORY

1. What school do you attend? _____ Public Private Grade: _____
2. What type of grades do you receive? _____
3. Have your grades changed recently? _____
4. How do you get along with your teachers and other school personnel? _____
5. Have you ever been suspended? No Yes When? _____ Why? _____
6. Do you get detentions? No Yes Why? _____
7. How do you compare with other students? _____

SOCIAL HISTORY

1. List your hobbies and interests: _____
2. Are you basically (circle): SHY FRIENDLY ENTHUSIASTIC FOLLOWER LEADER
3. Have your friends changed recently? How? _____
4. Do your parents know your friends? No Yes
5. What do you do with your friends? _____
6. How satisfied are you with your social life? Very Satisfied Satisfied Dissatisfied
7. Do you date? _____ Do you have a boyfriend/girlfriend now? _____ How long? _____

CHILD HISTORY QUESTIONNAIRE

(To be completed by Parent/Guardian.)

IDENTIFICATION

NAME OF CHILD: _____

ADDRESS: _____

SCHOOL: _____

RELIGION: _____

REFERRED BY: _____

TODAY'S DATE: _____

DATE OF BIRTH: _____

SEX: Male Female AGE: _____

HOME PHONE: _____

GRADE: _____

ETHNIC BACKGROUND: _____

CURRENT PROBLEM

1. Please briefly describe the major problem for which you are seeking help: _____

2. How long has your child had this problem? _____

3. What other problems would you like help with? _____

4. Has your child ever seen a counselor of any kind before? When? Why? _____

5. What led you to seek help at this time? _____

6. What is the likelihood that you will achieve your goal?

Not at all likely Slight possibility Good chance Probably Very likely

7. Who else knows about this problem? _____

PROBLEM CHECKLIST

Please check each of the items below that your child has experienced recently:

difficulty concentrating talks of harming self social problems feels misunderstood

seeing things that aren't there tires easily and often act before thinking eating disorder

hearing things sad and blue in trouble with the law bedwetting

trouble with memory angry sexual issues physical complaints

distrustful of others acting out relationship problems loss of appetite

unreasonable fears aggressive/violent school problems trouble sleeping

anxious and tense rebellious family problems chronic illness

panic attacks use of alcohol or drugs other: _____

MEDICAL HISTORY

1. Who is your child's physician? _____

2. Please list any medications your child is currently taking: _____

3. How would you characterize your child's health? Excellent Good Fair Poor

4. Please describe any current health problems and treatment that your child is receiving: _____

5. Has your child ever been hospitalized for a medical problem (age, reason)? _____

6. Has your child ever been hospitalized for an emotional problem (age, reason)? _____

7. Does your child have any allergies? No Yes – To what? _____

INTERPERSONAL HISTORY

1. How does your child relate to peers? _____
2. Is your child basically: Shy Friendly Enthusiastic Follower Leader
3. What types of leisure activities does your child enjoy? _____
4. Does your child currently belong to any clubs, teams, or organizations? _____
5. Has there been any recent change in your child's social activities? _____
6. What do you think are your child's most positive behavioral characteristics: _____
7. What behaviors concern you? _____
8. How do you respond when your child misbehaves? _____
9. How does your child typically respond to discipline? _____

EDUCATIONAL HISTORY

1. In what school subjects or situations does your child perform best? _____
2. In what school subjects or situations does your child perform worst? _____
3. What grades does your child receive? _____
4. Has your child's school performance changed? No Yes (how?): _____
5. Has your child been enrolled in any special educational program? No Yes (type, when, where?): _____
6. Has your child ever repeated any grades: No Yes (which ones?): _____
7. Has your child ever been on academic probation: No Yes (when?): _____
8. Has your child ever been suspended: No Yes (when, why?): _____
9. Has your child ever been expelled? No Yes (when, why?): _____

FAMILY HISTORY

1. Have any of your child's relatives suffered from or received treatment for any of the following? Depression
 Anxiety Disorders Eating Disorders Alcohol Problems Drug Problems Schizophrenia
 Bipolar Disorder ADD/ADHD

2. Please complete the following information regarding your child's parents:

	Mother	Father	Stepmother	Stepfather
AGE	_____	_____	_____	_____
OCCUPATION	_____	_____	_____	_____
EDUCATION	_____	_____	_____	_____
RELIGION	_____	_____	_____	_____
YEAR OF DEATH/CAUSE	_____	_____	_____	_____
CURRENT MARITAL STATUS	_____	_____	_____	_____

3. Who lives in the home (please include ages of other children)? _____
4. Which family members live outside of the home? Where? Why? _____
5. How does your child get along with his/her siblings? _____
6. What is your child's birth order (i.e., 1st of 3): _____

Please list any other pertinent information not previously asked: _____

