

ADOLESCENT QUESTIONNAIRE

Ages 12-18

This form will assist your therapist in knowing about you and will be kept confidential. Please print clearly.

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?**

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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.

	<u>Past</u>	<u>Now</u>
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?

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Adolescent Checklist of Characteristics		
Accident prone	Head banging	Procrastinates
Affectionate	Hitting	Provokes others
Aggressive	Hostile	Rages
Argues, "talks back," defiant	Hyperactive	Recent move, new school, loss of friends
Assaults	Hypochondriac, always complains of feeling sick	Refuses
Bathroom language	Imaginary playmates, fantasy	Relationships with friends are poor
Bigoted	Immature, "clowns around," has only younger playmates	Relationships with siblings –competition, fights, teasing/provoking
Bossy to others	Inappropriate sexual behaviors	Relationships with teachers poor
Breaks rules	Inattentive	Resists
Breaks the law	Independent	Responsible
Bullied by others	Inflicts pain on others	Restless
Bullies/ intimidates, teases, inflicts pain on others	Insults others	Rocking motion/behavior
Cheats	Interrupts, talks out, yells	Repetitive movements
Clowns around	Intimidated by others	Runs away
Competition	Intimidates others	Sad, unhappy
Complains	Intolerant	School avoiding
Complains of feeling sick	Irritability	Self-harming behaviors—biting, hitting self, scratching
Compliant	Isolates	Sexual preoccupation, inappropriate sexual behaviors
Concern for others	Lacks organization, unprepared	Sexually active
Conflicts at school	Lacks respect for authority, insults, dares, provokes	Shy, timid
Conflicts at home with parents over rule breaking, money, chores, choices	Learning disability	Slow moving
Conflicts with friends	Legal difficulties, truancy, loitering, vandalism, drinking	Slow responding
Conflicts with police	Lethargic	Smart-alecky
Cries easily, feelings are easily hurt	Likes to be alone, withdraws, isolates	Smoking
Cruel to animals	Loitering	Social
Dares others	Loss of friends	Speech difficulties
Dawdles, procrastinates, wastes time	Low-frustration tolerance, irritability	Stealing
Daydreams	Lying	Stubborn
Defiant	Manipulates	Suicide talk or attempt
Dependent, immature	Masturbation	Swearing, blasphemes, bathroom language, fowl language
Destructive	Mental retardation	Talks back
Developmental delays	Moody	Teased, picked on, victimized, bullied
Difficulties with parent's paramour/new marriage	Mute – refuses to speak	Teases others
Disobedient, uncooperative	Nail biting	Temper-tantrums, rages
Disrupts family activities	Name calling	Threatens
Distractible, inattentive, poor concentration, daydreams	Needs high supervision at home over play/chores/schedule	Thumb sucking, finger-sucking
Dropping out of school	Negativism	Tics – involuntary rapid movements, noises or word productions
Drug or alcohol use	Nervous	Timid
Drug sales	New school	Truancy, school avoiding
Eating issues, poor manners, over/under eats, refuses	Nightmares	Uncooperative
Exercise problems	Noisy	Uncoordinated, accident-prone
Extracurricular activities interfere with academics	Noncompliant	Under-active, slow-moving
Failure in school	Obedient	Unhappy
Fantasy life	Obesity	Unprepared
Fearful	Only younger playmates	Vandalism
Feelings are easily hurt	Oppositional, resists, refuses, does not comply, negativism	Violent
Fidgety	Outgoing	Wastes time
Fighting, hitting, violent, aggressive, hostile, threatens	Out-of- seat behaviors	Wetting/soiling of bed or clothes
Finger sucking	Overactive, restless, hyperactive, restlessness, fidgety	Withdraws
Fire starting	Picks on others	Yells
Fire setting	Poor concentration	Other
Friendly, outgoing, social	Pouts	
Hair chewing, pulling	Prejudiced, bigoted, insulting, name calling	