ADOLESCENT QUESTIONNAIRE—TO BE COMPLETED BY ADOLESCENT

The information you provide is confidential between you and your counselor unless there is an immediate risk to your safety. Please fill it out as thoroughly as possible.

The following questions are asked so that your counselor can best understand you. Please read the questions carefully and answer them as fully as possible. If there are questions you don't understand, they can be filled out with the counselor's help when you review the history together.

My Information

Name:________________________ Birth Date:________________ Age:__________

Home Address:____

Home Phone:______________________ Cell Phone:______________________

Parent/Guardian Names:________________ Phone:______________________

School:______________________ Grade:______________

What brought you to counseling? What concerns do you or your parent/guardian have?________________

____

How have you tried to deal with it? ______________________________________

How long have you had these concerns? Please circle one:

0-3 months   3-6 months   6-12 months   1-2 years   3-5 years   6 or more years

Who have you told about these concerns? Please circle all that apply:

Friends   Family   Supportive Adult   Boyfriend/Girlfriend   Religious/Spiritual Leader   Other:__________

Please check all that apply:

- ☐ I am sad
- ☐ I prefer to be alone
- ☐ I feel hopeless
- ☐ I am depressed
- ☐ I feel worthless
- ☐ I am easily irritated
- ☐ I lost interest in doing things I used to like
- ☐ I have low self-esteem
- ☐ I am tired all the time
- ☐ I can't fall asleep at night
- ☐ I eat too little or too much
- ☐ I have low energy
- ☐ I have stomach and/or body aches
- ☐ I have or had thoughts of suicide
- ☐ I self harm/injure
- ☐ I seem too happy
- ☐ I am more talkative than usual
- ☐ I have racing thoughts
- ☐ I do things without thinking
- ☐ I have mood swings
- ☐ I have been exposed to a traumatic event
- ☐ I am anxious
- ☐ My heart races a lot
- ☐ I have difficulty breathing

Please check all that apply:

☐ I have feelings of panic
☐ I am fearful much of the time
☐ I have social anxieties
☐ I have repetitive thoughts, rituals and/or behaviors (e.g., counting, washing, not throwing away)
☐ I have repetitive movement (e.g. eye twitching, rocking)
☐ I have frequent nightmares
☐ I am anxious when away from home
☐ I have a ____________ phobia
☐ I worry
☐ I struggle to get the grades I want
☐ I don't pay attention to details
☐ I don't seem to listen
☐ I am very fidgety when spoken to
☐ I am easily distracted
☐ I am disorganized
☐ I struggle to follow through tasks
☐ I am overactive or hyper
☐ I am always "on the go"
☐ I act without thinking
☐ I don't like my body
☐ I wish I was born the opposite gender
☐ I have questions about my sexual orientation
☐ I hear voices that other people don't
☐ I pull my hair/eyelashes when stressed
☐ I spend a lot of time using phone/computer/gaming
☐ I do not like to follow the rules
☐ I argue with friends
☐ I argue with adults
☐ I break things
☐ I am cruel to animals
☐ I start fires
☐ I steal things
☐ It is hard to tell the truth
☐ I try to avoid going to school
☐ I have been involved with the police
☐ I have run away from home
☐ I drink, smoke and/or use drugs
☐ I bully others
☐ I struggle with social skills
☐ I would like more friends
☐ I have been bullied
☐ I have been physically abused
☐ I have been sexually abused
☐ I have watched porn
☐ I have sexted
☐ I have had sexual experiences
☐ I have been pregnant
☐ My menstrual cycle is not consistent
☐ Other: ____

About You

What 3 words would your FRIENDS use to describe you? ____

What 3 words would your PARENTS/GUARDIANS use to describe you? ____

If you had 3 wishes, what would they be? ____
____
____

What do you want to be when you are older? ____
____

What are your strengths? ____
____

If you could change anything about yourself, what would you change? ____
____

Please Complete the Following Sentences

I am happy when ______________________________.

I am sad when ______________________________.

I am angry when ______________________________.

How do you feel when at home? ______________ at school? __________ with friends? __________

What is going well in your life? ______________________________
____

Family

Who do you live with?______________________________

List any family members who don't live with you (e.g., a sibling in college)?______________________________

Use 3 words to describe your parents/guardian(s): ______________________________
____

Describe your relationship with your siblings: ______________________________
____

Who do you get along with the BEST in your house? __________Please explain:______________________________
____

How do your parents/guardians get along?______________________________

Do they argue? ☐ Yes ☐ No If yes, what about and how often? ______________________________

How do you feel when they argue? ______________________________
____

Do you have any pets? ☐ Yes ☐ No If yes, please list: ______________________________

How much do you enjoy your pet/s? ______________________________

What are the top 3 things that you <u>like best</u> about your family? Please explain:______________________________
____

What are 3 things that you <u>do not like</u> about your family? Please explain:______________________________
____

Is there anything about you or your family's lifestyle that would be helpful to know? ______________________________
____

Your experiences while growing up can affect your life. What experiences and events have been important in your life? ______
____
____

What are the rules in your home? ____
____

Are there any weapons in your home? If yes, please explain: ______________________________________

What limits do you have on use of screen time (e.g., cell phone, TV, gaming, tablet, computer)? ______________
____

Who gives out punishments and privileges? ______________________________

What do you think about your punishments and privileges?______________________________________

Do you have chores? ☐ Yes ☐ No If yes, what are they? ____________________________________

Do you get an allowance? ☐ Yes ☐ No If yes, how much?______________________________________

Values/Spiritual/Religion

Do you have a belief system that influences your life? Please circle all that might apply:

Cultural Moral Religious Spiritual Other: ________________________

Do you believe in God/Higher Power? ☐ Yes ☐ No ☐ Unsure ☐ Don't care ☐ Other:__________________

Do you have any religious affiliation? ____________________________ Are you active? ☐ Yes ☐ No

Describe your religious/spiritual upbringing: ____
____
____

School

What is going well with school? ____
____

Describe any academic concerns you have now or in the past: ____________________________________
____
____

List any concerns or conflicts you have at school that are not academic: ___________________________
____
____

Please check one:

How has your school attendance been THIS YEAR? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How has your school attendance been IN THE PAST? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What are your favorite subject(s)? ______________________________

What is your least favorite subject(s)? ______________________________

What are your grades like? ____________________ Have they changed? __________

Please Complete the Following Sentences

Homework tends to ______________________________.

My favorite teacher ______________________________.

My least favorite teacher ______________________________.

Social

How would you describe making friends for you? ☐ Very Easy ☐ Easy ☐ In Between ☐ Hard ☐ Very Hard

How many close friends do you have? __________ About how many acquaintances? __________

What do you like most about these friendships?______________________________

What do you like least about these friendships? ______________________________

Has there been a change in friends recently? ☐Yes ☐No If yes, please explain:____________________

Have your friends ever been in trouble with the police? ☐Yes ☐No If yes, please explain:____________________

What do you prefer (check all that apply)?

☐ Large Groups ☐ Small Groups ☐ One Best Friend ☐ Be Alone ☐ Online Friends ☐ Other:__________

What activities are you involved in? Circle any that apply:

Sports Clubs Job/volunteer Religious Organization Hobbies Other:__________

Please list any activities and what do you like least and most about your activities? ____________________

Medical

Do you have any medical concerns now or in the past (e.g., surgeries, allergies, diabetes, cancer)? ☐ Yes ☐ No
If yes, please explain when and reasons:________________________________

Have you received counseling in the past? ☐ Yes ☐ No If yes, please explain when and reasons:________________

Quality of experience with counselor (rate by circling a number): (Negative) 1 2 3 4 5 (Positive)

Have you seen a psychiatrist? ☐ Yes ☐ No If yes, please explain when and reasons:________________

Quality of experience with psychiatrist (rate by circling a number): (Negative) 1 2 3 4 5 (Positive)

If you do not take any medications for emotional concerns, would you consider it? ☐ Yes ☐ No Please explain:________

If you do take medication, do you feel it is helping? ☐ Yes ☐ No Please explain:________________

How helpful do you think counseling will be to you (rate by circling a number): (Helpful) 1 2 3 4 5 (Not Helpful)

Is there anything that your counselor should know about you? ________________

Do you have any concerns or questions about counseling? ________________

Do you have concerns or questions about your confidentiality/privacy? ________________

What would you like to work on or help with in counseling? ________________

THANK YOU FOR YOUR TIME.