

Date: \_\_\_\_\_

# INTAKE INFORMATION

## Teen Questionnaire

Instructions: To assist in helping you, please fill out this form as fully and openly as possible. All of the information on this form is held in the strictest confidence within legal limits. If certain questions do not apply, please leave them blank.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: M/F What grade are you in? \_\_\_\_\_ Name of School: \_\_\_\_\_

Do you work?  Yes  No If yes, where? \_\_\_\_\_

How many hours/week on average do you work? \_\_\_\_\_

### **Presenting Problem(s):**

What issues or problems bring you to therapy? \_\_\_\_\_

\_\_\_\_\_

How long have these issues/problems occurred? \_\_\_\_\_

To what extent do these issues/problems impact your daily life or functioning?

- not at all  very little  some  quite a bit  severely

What do you hope will change as a result of this therapy? \_\_\_\_\_

\_\_\_\_\_

### **Medical History/Information:**

Do you have any concerns about your physical health? If **yes**, please specify: \_\_\_\_\_

\_\_\_\_\_

Please list any psychotherapy or chemical dependency treatment you have received in the past: \_\_\_\_\_

\_\_\_\_\_

How would you describe the result of that psychotherapy? What was helpful about it? \_\_\_\_\_

\_\_\_\_\_

### **Family Background:**

Father's name: \_\_\_\_\_

What is your relationship with your father like? \_\_\_\_\_

\_\_\_\_\_

Is there anything you would like to change about your relationship with your father? If **yes**, please specify: \_\_\_\_\_

\_\_\_\_\_

Briefly describe your father's alcohol/drug use: \_\_\_\_\_

Mother's name: \_\_\_\_\_

What is your relationship with your mother like? \_\_\_\_\_

Is there anything you would like to change about your relationship with your mother? If **yes**, please specify: \_\_\_\_\_

Briefly describe your mother's alcohol/drug use: \_\_\_\_\_

Do you think your parents are:     too strict         Not strict enough         just about right  
Are your parents:                     Married                     Separated                     Divorced                     Remarried  
Step-parent(s) name(s): \_\_\_\_\_

How would you describe your relationship with your step-parent(s)?  
Step-mom: \_\_\_\_\_

Step-dad: \_\_\_\_\_

If your parents are divorced, please describe the details of the custody/visitation schedule (i.e. when you are with each parent): \_\_\_\_\_

If you could, is there anything you would change about this schedule? \_\_\_\_\_

Brothers and sisters: (indicate if step-brother or step-sister)

Name	Age	Sex	Grade in school/occupation	Living at home?

Of your siblings, who are you closest to: \_\_\_\_\_

Who do you fight with the most? \_\_\_\_\_

Have any of the following stressful events occurred in the life of your family? If so, please indicate which ones, to whom it may have occurred and how old you were when it/they occurred.

- Death                     Major illness                     Sexual abuse                     Physical abuse                     Verbal abuse  
 Divorce                     Change in residence                     Foster placement                     Hospitalization                     Other

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**Personal Information:**

List any extracurricular (in and out of school) activities in which you are involved: \_\_\_\_\_

What do you like/dislike about school? \_\_\_\_\_

List a few things you like about yourself and/or what others would say they like about you: \_\_\_\_\_

List a few things about yourself or your life you don't like or would like to change? \_\_\_\_\_

Please list some of your hobbies and interests: \_\_\_\_\_

Any concerns about your relationships with friends? If **yes**, please describe: \_\_\_\_\_

What are your biggest fears? \_\_\_\_\_

**Symptom Check-List:**

Listed below are a number of common symptoms. Please check **ALL** that apply to you  
(rate the severity for each one you've checked on a scale from 1-5; 1 = least severe 5 = most severe):

- |  |   |   |
|--|---|---|
| <input type="radio"/> Frequent headaches                       | <input type="radio"/> Often tired/exhausted             | <input type="radio"/> Weight loss/gain              |
| <input type="radio"/> Nausea/stomach trouble                   | <input type="radio"/> Problems sleeping                 | <input type="radio"/> Withdrawn                     |
| <input type="radio"/> Unhappy/sad                              | <input type="radio"/> Lonely/empty                      | <input type="radio"/> Sudden changes in mood        |
| <input type="radio"/> Fearful/worried                          | <input type="radio"/> Bored/uninterested in most things | <input type="radio"/> Hopelessness                  |
| <input type="radio"/> Feeling worthless                        | <input type="radio"/> Numb-don't feel much of anything  | <input type="radio"/> Nightmares                    |
| <input type="radio"/> Feelings of panic                        | <input type="radio"/> Crabby/irritable                  | <input type="radio"/> Frustrated                    |
| <input type="radio"/> Unable to concentrate                    | <input type="radio"/> Can't make decisions              | <input type="radio"/> Self-critical                 |
| <input type="radio"/> Suicidal thoughts                        | <input type="radio"/> Poor grades                       | <input type="radio"/> Thoughts of hurting others    |
| <input type="radio"/> Worries about my health                  | <input type="radio"/> Defy/break rules                  | <input type="radio"/> Dishonest/lying               |
| <input type="radio"/> Angry outbursts/often angry              | <input type="radio"/> Physical fights                   | <input type="radio"/> Try too hard to please others |
| <input type="radio"/> No friends                               | <input type="radio"/> Feelings of guilt/shame           | <input type="radio"/> Argue with parents            |
| <input type="radio"/> Keep secrets                             | <input type="radio"/> Skip school                       |   |
| <input type="radio"/> Engage in sexual behavior you don't like |   | <input type="radio"/> Sexual orientation issues     |

- Repeats certain acts again and again
- Other-please specify:

- Self-injury (cutting, picking, burning)

### **Nutrition:**

Nutrition is very important to a person's physical health and mental well-being. This is a simple screen to help us determine any nutritional risks you may have.

Do you:

- |   |                           |                          |
|---|---------------------------|--------------------------|
| 1. Eat breakfast most mornings?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Eat lunch at school?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Does your family eat meals together most days?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Exercise daily?  | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Eat a balanced diet including a variety of food and adequate amounts<br>(such as 3-5 servings of fruits & vegetables per day and 2-3 servings of milk) | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Lost or gained over 10 pounds in the last 6 months without trying?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Suspect that you may have an eating disorder?  | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. Spend more than 4 hours with the TV or computer each day?  | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Have any special dietary needs? (i.e. pregnancy, diabetes, allergies, etc.)  | <input type="radio"/> Yes | <input type="radio"/> No |
| 10. Take herbal supplements or other over-the-counter medications?  | <input type="radio"/> Yes | <input type="radio"/> No |

Please list any other concerns about your diet that we should know about: \_\_\_\_\_

### **Chemical Use History:**

1. Have you ever used alcohol or drugs?  Yes  No If **YES**, complete the questions below:
  - a. Used more than one chemical at the same time in order to get high?  Yes  No
  - b. Avoid family activities so you can use?  Yes  No
  - c. Have a group of friends who use?  Yes  No
  - d. Use to improve emotions such as when you may feel sad or depressed?  Yes  No

### **Additional Comments:**