



Child, Adolescent and Family Services
Northern California

MR #: _____

Name: _____

DATE

ADOLESCENT QUESTIONNAIRE (12 and Above)

IMPRINT AREA

NAME	AGE	
ADDRESS (STREET)	CITY, ZIP CODE	PHONE NUMBER
MEDICAL RECORD #	ETHNICITY/COUNTRY OF ORIGIN	RELIGION
SCHOOL	GRADE	JOB

Whose idea was it for you to be seen here today? Mine Parent(s) Other
 If someone other than you, are you okay with this idea? No Yes Not sure

For what problems are you seeking counseling/psychiatric help? _____

Have you ever seen a counselor in the past? No Yes

If so, whom? _____

When did you see the counselor? _____

Why did you see the counselor? _____

How was it helpful? _____

FAMILY HISTORY:

With whom do you live? (Check the most appropriate choice)

- Both parents Other family
 Mother Someone else,
 Father Specify: _____

Present amount of contact with parents:

- | | |
|--|--|
| Father (if deceased, give date _____) | Mother (if deceased, give date _____) |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Weekly |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Once per year or less | <input type="checkbox"/> Once per year or less |
| <input type="checkbox"/> Never | <input type="checkbox"/> Never |

Describe your family:	Mother	Father	Stepmother	Stepfather	Brother	Sister	Other
Likes me							
Kind							
Pleasant							
Understanding							
Easygoing							
Rarely home							
Strict							
Mean							
Harsh							
Critical							
Negative							
Angry							
Uses drugs							
Uses alcohol							
Verbally abusive							
Physically abusive							

Kind of punishment – indicate who:

	Mother	Father	Stepmother	Stepfather
Sends you to your room				
Takes away privileges				
Restricts or grounds you				
Spanks/hits				
Other, Please explain:				

MEDICAL HISTORY:

Do you have or have you ever had any significant medical problems or been hospitalized? No Yes

If so, please list: _____

Are you on any medications? (Include birth control pills) No Yes

If so, please list: _____

Have you been or are you now sexually active? No Yes

If yes, do you practice safe sex? No Yes

What is your sexual preference/orientation? _____

For females: Have you started your period? No Yes At what age? _____

Are you pregnant? No Yes

Have you ever been pregnant? No Yes

Have you ever drunk alcohol? No Yes

How often? Daily Weekly Rarely

Do you smoke or use tobacco? No Yes

Do you use drugs? No Yes

If so, what kind? _____

	NOW	PAST	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	
Crank	<input type="checkbox"/>	<input type="checkbox"/>	
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	
LSD	<input type="checkbox"/>	<input type="checkbox"/>	
Inhalant	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	Please specify: _____

Does your habit hurt your relationship with others? No Yes

Does it interfere with your performance at school? No Yes

How long ago did your habit begin? _____

Do you think it's a problem? No Yes

Would you like to stop your habit? No Yes

LEGAL HISTORY:

Have you ever had police/court involvement? (Check one answer)

No, never Yes, within the past month Yes, within the past 6 months Yes, within the past year Yes, over 1 year ago

Do you see a social worker or probation officer on a regular basis? No Yes

If so, name, address and phone number: _____



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SYMPTOMS:

Have you had any of the following experiences or problems, now or in the past?

	Current	Past		Current	Past		Current	Past
Restless and unable to sit still			Hurt animals			Slurred speech		
Act without thinking			Sneak out at night			Eat little or fast to lose weight		
Difficulty paying attention			Hurt people			Vomit food intentionally		
Low motivation			Sexual problems			Gorge food		
Short attention span			Problems with the law			Hearing voices or seeing things that aren't there		
Easily frustrated			Fire-setting			Headache		
Easily distracted			Been arrested, in jail or on probation					
Daydream or fantasize a lot						Sadness, crying &/or depression		
Temper outbursts			Nervous/can't relax			Hard to make decisions		
Uncooperative			Worry more than others			Irritable/angry		
Back talk			Very anxious			Withdrawn from others		
Hard to admit mistakes			Worry a lot about past behavior			Trouble concentrating		
Argue a lot			Fearful			Trouble going to sleep		
Enjoy "bugging" people			Worry a lot about the future			Memory problems		
Swear or use obscene language			Unusual fears or phobias			Restless sleep, wake up frequently		
Easily annoyed by others			Panic			Nothing fun anymore		
			Overly concerned about germs, safety, and/or health issues			Wake up very early and can't go back to sleep		
Use alcohol/drugs			Repeat an act over and over that is not necessary to do (e.g., washing, checking locks, counting, lining things up)			Cutting or injuring myself		
Smoke cigarettes						Sleep too much		
Rebellious attitude or behavior			Seem confused a lot			Feeling tired and fatigued		
Damaged property			Can't control body movement			Nightmares, night fears		
Want to run away from home			Not knowing where you are			Weight gain or weight loss		
Stolen things			Feeling odd or different than other people			Have made suicide attempts in the past		
Have run away from home			Blurred or double vision			Low self-esteem		

Have you had any of the following experiences or problems, now or in the past?

	None of the time	Some of the time	Good part of the time	Most or all of the time
I feel it is too painful to keep on living				
I feel my family would be better off if I were dead				
I think about suicide				
I have thought of how to kill myself				
In order to punish others, I think of suicide				

continued on next page

Check the boxes that describe your relationships with others:

- | | |
|--|---|
| <input type="checkbox"/> Prefer to be alone | <input type="checkbox"/> I have a best friend |
| <input type="checkbox"/> Alone a lot, but dislike this and feel lonely | <input type="checkbox"/> I have a lot of friends |
| <input type="checkbox"/> Problem getting along with others | <input type="checkbox"/> I go out with friends. Where?
_____ |
| <input type="checkbox"/> Shy | |
| <input type="checkbox"/> Difficulty getting along with my brothers and sisters | <input type="checkbox"/> I have a steady boyfriend/girlfriend. Their age?
_____ |
| <input type="checkbox"/> Family member drinks too much | <input type="checkbox"/> Conflict with my parents or step-parents |
| <input type="checkbox"/> Family member uses drugs | <input type="checkbox"/> Being physically or sexually abused |
| <input type="checkbox"/> Family member, relative, or friend
tried to kill himself/herself | <input type="checkbox"/> Being neglected |
| | <input type="checkbox"/> Getting picked on a lot by peers? _____
By family member? _____ |

I have had these problems at school:

- | | |
|--|--|
| <input type="checkbox"/> Difficulties with classmates | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> Not having friends at school | <input type="checkbox"/> Have been on detention (or Saturday school) |
| <input type="checkbox"/> Not getting along with teachers | <input type="checkbox"/> Been suspended (# of times _____) |
| <input type="checkbox"/> Cutting school or classes | <input type="checkbox"/> Been expelled (# of times _____) |
| <input type="checkbox"/> Poor grades | <input type="checkbox"/> Getting into fights at school |

Additional Comments: _____

PATIENT'S SIGNATURE

DATE