



Child, Adolescent and Family Services  
Northern California

IMPRINT AREA

**ADOLESCENT QUESTIONNAIRE (12 and Above)**

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

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

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 drank 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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Date:

**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)			Low self-esteem		
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					

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

	None or a little 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**

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**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?<br>_____                             |
| <input type="checkbox"/> Shy   | <input type="checkbox"/> I have a steady boyfriend/girlfriend. Their age?<br>_____          |
| <input type="checkbox"/> Difficulty getting along with my brothers and sisters               | <input type="checkbox"/> Conflict with my parents or step-parents                           |
| <input type="checkbox"/> Family member drinks too much                                       | <input type="checkbox"/> Being physically or sexually abused                                |
| <input type="checkbox"/> Family member uses drugs  | <input type="checkbox"/> Being neglected  |
| <input type="checkbox"/> Family member, relative, or friend<br>tried to kill himself/herself | <input type="checkbox"/> Getting picked on a lot by peers? _____<br>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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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PATIENT'S SIGNATURE

DATE



**CONFIDENTIALITY AND CONSENT TO TREATMENT**

IMPRINT AREA

**Mental Health and Chemical Dependency**

Your Kaiser Permanente Psychiatry Department is strongly committed to your right to privacy. Toward this end, records related to your visits in the Psychiatry Clinic are generally kept separate from your medical record. However, for your safety, any medications you may be prescribed in the Psychiatry Clinic are noted in your medical chart. Information might be exchanged between a Kaiser Permanente mental health provider and another Kaiser Permanente provider when the information is pertinent to the direct clinical care of the individual.

Also, there are some specific circumstances when California law requires the release of certain psychiatric information. For example, if you are involved in certain legal actions in which your emotional or mental state is an issue, we may be required by law to release information from your psychiatric records to parties involved in that legal action. Any time you are asked to sign a release of information, talk to your therapist if you have any concerns about what is in your record.

In addition, we may be required to report, to police or other governmental agencies, certain information that relates to either actual or potential violent or abusive acts of which we might become aware.

**Consent to Treatment**

Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part if you are going to get something out of it. In addition, there may be certain kinds of risks involved. For example, the therapy process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks. In fact, sometimes there can be more risks associated with **not** participating in therapy.

If you see a physician as part of your care, he or she may prescribe medication for you. If so, you'll be advised at that time of the benefits and any risks of the medications.

It is important that you participate in this treatment willingly. If you have any questions or concerns about this document, about the services being provided to you, or about your treatment options, you should definitely ask your therapist.

**Acknowledgment**

By signing your name in the space below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this treatment. *If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in the treatment (except in certain legally exempt situations).*

PATIENT'S SIGNATURE (IF SIGNATURE OTHER THAN PATIENT, LIST RELATIONSHIP)	DATE
WITNESS' SIGNATURE	DATE