TEEN QUESTIONNAIRE
Ages 13-18

CLIENT DEMOGRAPHICS

Client Name:____ Date:______________

Birth date: _____/_______/_____ **Age:**______ **Gender:** Female Male

Address____

____

____

Phone Number____

Legal Guardian/s____

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?**

____

____

____

13. What do you like to do to have fun?

____

____

____

____

FAMILY HISTORY

1. ABOUT **YOUR HOUSEHOLD**

Name	Age	Relationship to You	How do you get along?

2. **Important people in your life** (immediate family/relatives/significant others)

Name	Age	Relationship to You	How do you get along?

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).**

First Name	Time Together	Relationship	Reason for Ending

SEXUAL HISTORY if Necessary:

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:**

Concern	Person(s) Who Experienced This
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**?

____

____

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**? ____________________________

Risk Assessment

SUICIDE/HOMICIDE

Have you **ever had** or **do you have**? Check all that apply.

	Past	Now
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.

	Past	Now
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	____	____

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

____
____
____
____
____
____