CEDAR CREEK ASSOCIATES
Private, Independent Practitioners

ADOLESCENT QUESTIONNAIRE

PERSONAL INFORMATION:

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Please list any person living in your home:

Name	Age	Relationship	Quality of Relationship

Please list other immediate family members not currently living in your home:

Name	Age	Relationship	Quality of Relationship

Mother's occupation: _____ Father's occupation: _____

Family's religion: _____ Do you attend? _____

Were you adopted? _____ If so, at what age? _____

Have you had any contact with your biological parents since the adoption? _____

How do you believe your family manages conflict? _____

Are there other family-related issues your therapist might need to know about?

_____

EDUCATIONAL INFORMATION:

School: _____ Grade: _____ Have you ever failed a grade or been held back? _____ If so, please explain: _____

Have you ever received special education, special resource, or speech services? _____ If so, please explain: _____

What activities in and out of school do you do? _____

_____

What kind of grades do you typically make? _____

MEDICAL INFORMATION:

Physician: _____ Date of last physical exam: _____

Please list any illnesses or medical conditions: _____

Please check and explain any concerns or events from the list below:

_____ Your weight or diet: _____

_____ Weight loss or gain of more than five pounds in the past year? _____

_____ Have you ever been unconscious from a head injury? _____

_____ Have you ever been neglected, traumatized, or abused? _____

_____ Have you had previous counseling or testing? _____

_____ Have you tried, or do you use, dugs, tobacco, or alcohol? _____

_____ Have you ever received treatment for drug or alcohol use? _____

_____ Do you drink caffeine (sodas, tea, coffee, energy drinks) and how much? _____

_____ Have you ever been hospitalized? _____

_____ Have you ever been the victim of a crime? If so, please explain:

_____

SOCIAL/RECREATIONAL INFORMATION:

Please list your hobbies and interests: _____

Do you have a best friend? _____ Do you have a TV in the bedroom? _____

Estimate the number of hours per week you watch TV: _____

Estimate the number of hours per week you play video or computer games: _____

PRESENTING PROBLEM:

Please explain why you are seeking treatment: _____

_____

How severe are these concerns to you? _____ Mild _____ Severe _____ Extremely severe

How severe are these concerns to your parents? ____ Mild ____ Severe ____ Extremely severe

When did the problem(s) begin? _____

What have you done to try and solve the problems? _____

Please check any symptoms you are having:

____ Tiredness	____ Difficulty sleeping	____ Increased tears
____ Argues a lot	____ Loss of interest in activities	____ Nervousness
____ Irritability	____ Withdrawal from others	____ Conflicts
____ Worry	____ Changed eating habits	____ Destructive
____ Thoughts of hurting self	____ Thoughts of suicide	____ Poor attention
____ Aggressive behavior	____ Thoughts of hurting others	____ Nightmares
____ Loss of appetite	____ Grades have dropped	____ Over sleeping
____ Over-eating	____ Confusion	____ Can't focus
____ Poor concentration	____ Memory problems	____ Depressed
____ Increased anxiety	____ Panic attacks	____ Feel paranoid

____ Other: _____

Please check any recent check any recent changes you have experienced:

____ Illness or injury	____ Family moved	____ Friend moved
____ Sibling left home	____ New family member	____ Parent left home
____ Loved one died	____ Experienced or witnessed violence	____ Parents divorced

____ Child moved into/away from family

____ Other major loss or event: _____

____ Other: _____

Thank you. Your therapist will be happy to answer any questions or address any concerns you have about these questions.