Adolescent Questionnaire

NOTE: THIS FORM IS OPTIONAL! Any information you give me would help me to know more about you (rather than just what your parents say about you). If you would rather not, please feel free to answer only part or none of the questions.

Name _____ Age _____

How do you feel about being here?

( ) It's fine with me
( ) I don't care either way
( ) I'm against it

Have you ever seen a counselor before? ( ) Yes ( ) No

What event(s) or problems have caused you to come for counseling?_____

_____

_____

Health

Check all that apply to you:

( ) I have difficulty falling asleep.
( ) I wake up frequently during the night.
( ) I wake up very early and can't get back to sleep.
( ) I feel tired much of the time.
( ) I have gained or lost 10 lbs. or more within the past 2 months.
( ) I sometimes eat way too much or feel my eating is out of control.
( ) I sometimes vomit after eating too much to get rid of the food.
( ) I have a hard time concentrating.
( ) My memory is not as good as it used to be.
( ) I have stomach aches or headaches a lot.
( ) I have thoughts that trouble me sometimes.
( ) I worry a lot.
( ) Sometimes I wish I didn't have to go on living.

Check below the three (3) feelings you most often have:

( ) happy	( ) sad	( ) angry
( ) irritable/"touchy"	( ) anxious/nervous	( ) bored
( ) confused	( ) confident	( ) shy
( ) "hyped up"/energetic	( ) guilty	( ) depressed
( ) worried	( ) lonely	( ) worthless

List any medications you are currently taking: _____

School

What school do you go to? _____

What grade are you in? _____

What activities (if any) are you in at school (such as sports, music etc.)? _____

_____

What do you like the most about school? _____

What do you like the least about school? _____

Activities and Interests

What do you do for fun? _____

What activity would you like to do that you haven't done yet in your life? _____

_____

Friendships & Relationships

How much time do you spend with others your age? ( )a lot of time ( )some time ( )not much time

Do you have a "best" friend? ( ) Yes ( ) No

If so, how long have you known him/her? _____

Do you have a boyfriend/girlfriend? ( ) Yes ( ) No

If so, how long have you been dating? _____

Do people at school tend to label your group of friends (e.g. skaters, metalheads, preps, etc.)?

( ) Yes ( ) No

If so, what label would you usually be given?

_____

Do you have someone you can talk to about personal issues in you life? ( ) Yes ( ) No

If so, who? _____

How do you generally think of adults? (Please check all that apply)

( ) helpful
( ) friendly
( ) overly strict
( ) smart or wise most of the time
( ) can be trusted and counted on
( ) usually mean
( ) out of touch with you
( ) caring
( ) jerks
( ) stupid or dumb most of the time
( ) can't be trusted or counted on

Drug and Alcohol Use

	never	tried	rarely	monthly	weekly	daily
How often do you drink?	( )	( )	( )	( )	( )	( )
Smoke cigarettes?	( )	( )	( )	( )	( )	( )
Smoke marijuana?	( )	( )	( )	( )	( )	( )
Use cocaine/crack?	( )	( )	( )	( )	( )	( )
Use acid/LSD?	( )	( )	( )	( )	( )	( )

Tried other drugs? (Please list) _____

Family

Describe your family in a few words: _____

_____

Who do you get along with the best in your family? _____

_____

What would you change about your family if you were given the power to do so? _____

_____

Faith

Do you currently attend church, synagogue, or mosque? ( ) Yes ( ) No

Are you involved in a religious youth group? ( ) Yes ( ) No

Have you had any positive or negative experiences related to your faith? ( ) Yes ( ) No

Please List: _____

General

What is your earliest memory from childhood? _____

_____

Please list any major changes in your life over the past five (5) years (e.g., moving, parents divorced, etc.): _____

_____

Is there anything else you want me to know about you? _____

_____

_____

_____ _____

Signature Date