Adolescent Intake Questionnaire

ADOLESCENT INTAKE QUESTIONNAIRE

What is the reason you are coming in for counseling? Please be as detailed as you can.

What do you think you need the most help with right now?

Please rank your concerns in the following areas on a scale of 1 to 10: 0 = No problems and 10 = Major problems. You may use the same number for more than one area.

Depression

0 1 2 3 4 5 6 7 8 9 10

Anxiety/Worry

0 1 2 3 4 5 6 7 8 9 10

Parents

0 1 2 3 4 5 6 7 8 9 10

Friends

0 1 2 3 4 5 6 7 8 9 10

Sex

0 1 2 3 4 5 6 7 8 9 10

School

0 1 2 3 4 5 6 7 8 9 10

Substance Use

0 1 2 3 4 5 6 7 8 9 10

Legal

0 1 2 3 4 5 6 7 8 9 10

Anger Issues

0 1 2 3 4 5 6 7 8 9 10

Suicidal Thoughts

0 1 2 3 4 5 6 7 8 9 10

Trouble eating food

0 1 2 3 4 5 6 7 8 9 10

SCHOOL AND SOCIAL FUNCTIONING

Are you currently in school? If so, what grade are you in?: _____

If you are attending, what is school like for you?

If attending, what school do you go to?: _____ What was your grade point average last report card?: _____

Are these grades better or worse than usual?: _____

Have you ever attended any special classes? If yes, list them below.

Do you have a learning disability? If so, what is the disability?: _____

During the past school year, about how many days were you absent when you were supposed to be in school?

Have you ever been suspended or expelled from school? If yes, please share additional details.

Have you ever been in trouble at school related to an alcohol or other drug problem? If yes, please share additional details.

MORE ABOUT YOU

What do you like to do for fun or enjoyment? Do you have any hobbies that you enjoy regularly? Do you prefer your enjoyment alone, with others, or both?

Are you sexually active?

◯ Yes ◯ No

Do you practice safe sex?

◯ Yes ◯ No

Do you currently drink alcohol? If so, describe the type, amount, and how often (daily, weekly, monthly, etc.).

Do you smoke cigarettes or use any nicotine products? If so, what and how often?

Do you currently use recreational drugs? If so, describe type, amount, frequency.

Has your drinking or drug use ever caused problems in your family, relationships, or job?: _____

Have you ever been arrested for a DUI or other drug related offense? If yes, please give dates and details.

Is it difficult for you to stop or control the amount you drink or use?

◯ Yes ◯ No ◯ Not Applicable

If you feel you have a problem with alcohol or drugs, would you like help?: _____

SYMPTOMS

Please check any symptoms that you currently experience or have experienced:

- ☐ Headaches
- ☐ Dizziness
- ☐ Excessive anger
- ☐ Excess energy
- ☐ Excessive spending
- ☐ Feeling irritable
- ☐ Mood swings
- ☐ Impulsive behavior
- ☐ Alcohol craving
- ☐ Eating problems
- ☐ Weight loss
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ Low energy
- ☐ Decreased pleasure
- ☐ Feeling hopeless
- ☐ Suicidal thoughts
- ☐ Attempted suicide
- ☐ Anxiety
- ☐ Fears
- ☐ Avoiding places of situations due to fear or panic/anxiety
- ☐ Feel that others are plotting against you
- ☐ Hearing voices that others do not hear
- ☐ Physical abuse
- ☐ Emotional/verbal abuse
- ☐ Relationship problems
- ☐ Fears of losing control
- ☐ Feeling the need to do/repeat things
- ☐ Unusual thoughts
- ☐ Thoughts of someone physically harming you
- ☐ Violent or aggressive behavior
- ☐ Restlessness
- ☐ Pain
- ☐ Less need for sleep
- ☐ Elated mood
- ☐ Racing thoughts
- ☐ Feeling wired
- ☐ Grandiose thoughts
- ☐ Confusion
- ☐ Drug craving
- ☐ Weight gain
- ☐ Loss of appetite
- ☐ Appetite changes
- ☐ Frequent nightmares
- ☐ Unable to have fun
- ☐ Feeling worthless
- ☐ Feeling isolated
- ☐ Suicidal plans
- ☐ Crying frequently
- ☐ Frequent worrying
- ☐ Panic attacks
- ☐ Concentration problems
- ☐ Constant suspicion or distrust
- ☐ Seeing things others do not see
- ☐ Sexual abuse
- ☐ Sexual problems
- ☐ Family conflict
- ☐ Unwanted thoughts or behaviors
- ☐ Obsessive/repetitive thoughts
- ☐ Strange experiences
- ☐ Thoughts of physically harming someone

For all symptoms ticked above, indicate when you experienced them.

PSYCHIATRIC HISTORY

Have you seen a mental health professional before? If so, please specify dates, the reason for counseling, and your experience. What was your diagnosis, if any?

If applicable, list all psychotropic medications you are currently taking, for how long, and for what reason.

If taking prescription medication, who is your prescribing doctor? Please include type of doctor, name, and phone number.

Do you have, or have you ever had, suicidal thoughts?

◯ Yes ◯ No

If yes, when and how would you end your life?

Have you ever attempted suicide?

◯ Yes ◯ No

If yes, lease list all attempts and your age when each happened, starting from the most recent event to the oldest event.

Have you ever been hospitalized for a psychiatric issue?

◯ Yes ◯ No

If yes, please describe why, when, and the length of your stay.

Do any family members struggle with the following challenges?

- ☐ Learning challenges/disability
- ☐ Alcoholism/drug addiction
- ☐ Trauma (sexual assault, combat, abuse, etc.)
- ☐ Eating disorders (Anorexia/Bulimia)
- ☐ Other
- ☐ Depression/Bipolar Disorder
- ☐ Anxiety/panic attacks
- ☐ Suicide attempts
- ☐ Hyperactivity/ADHD

Please specify which family member is struggling through the challenges ticked above.

FAMILY HISTORY

Please describe your relationship with your mother.

Please describe your relationship with your father.

Do you have siblings?

- ◯ Yes
- ◯ No

If yes, please describe your relationship with them.

If you are in a relationship, please describe the nature of the relationship and months or years together.

Who do you know that you would consider your closest sources of support or your "inner circle"?

What else would you like me to know?