Family Counseling Center
Adolescent's Questionnaire (ages 11- 17)
**For Parent/Guardian to Complete**

Adolescent's Name:_____ DOB:_____ Age:_____

School:_____ Grade:_____

Race/Ethnic Origin:_____ Religious Preference:_____

Family Members and Other Persons in Household

| Name | Age | Relationship To Child | Grade Or Occupation | Living In Household? | |
|---|---|---|---|---|---|
| | | | | Yes | No |
| | | | | Yes | No |
| | | | | Yes | No |
| | | | | Yes | No |
| | | | | Yes | No |

If different from above, please give:
Biological mother's name:_____
Biological father's name:_____

Problem Description

Please state the problems for which you want help for this adolescent:_____

_____

_____

_____

_____

_____

Previous mental health counseling and/or treatment:

Therapist/Program_____ Date:_____

Problem:_____

Therapist/Program_____ Date:_____

Problem:_____

## Emotional/Behavioral/Chemical Issues

Has your adolescent recently or currently experienced the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ___ | ___ | Recent Suicidal thoughts | ___ | ___ | Difficulty sleeping |
| ___ | ___ | Suicide plans | ___ | ___ | Depression, loneliness, or hopelessness |
| ___ | ___ | Suicide attempts and/or self-inflicted injury | ___ | ___ | Crying often |
| | | | ___ | ___ | Frightening dreams or thoughts |
| ___ | ___ | A tendency to be shy or sensitive | ___ | ___ | Often annoyed by little things |
| | | | ___ | ___ | Difficulty completing tasks |
| ___ | ___ | A strong dislike of criticism | ___ | ___ | Violent or destructive behavior |
| ___ | ___ | A frequent loss of temper | ___ | ___ | Difficulty remembering |
| ___ | ___ | Difficulty expressing feelings | ___ | ___ | Difficulty concentrating |
| ___ | ___ | Nervousness, anxiety, or worry | ___ | ___ | Mental Confusion |
| ___ | ___ | Difficulty relaxing | ___ | ___ | Difficulty with eating |
| ___ | ___ | Difficulty making decisions | | | |

Has your adolescent ever been in court or picked up by the police? _____ Yes _____ No.

If yes, describe:_____

Do you think your adolescent has tried cigarettes, sniffing, alcohol or drugs? ____ Yes ____ No

If yes, describe:_____

## Child Development

1. Were there any complications with the pregnancy or delivery of your adolescent? ___ Yes ___ No

If yes, describe:_____

_____

2. Did your adolescent have health problems at birth? _____ Yes _____ No

If yes, describe:_____

3. Did your adolescent experience any developmental delays (e.g. toilet training, walking, talking)?

___ Yes ___ No ___ Not sure If yes, describe:_____

_____

4. Did your adolescent have any unusual behaviors or problems prior to age 3? ___ Yes ___ No ___ Not sure

If yes, describe:_____

5. Has your adolescent experienced emotional, physical, or sexual abuse? ____ Yes ____ No ____ Not sure

If yes, describe:_____

## Peer Relations

1. Is your adolescent socially: ___outgoing ____shy ____depends on the situation.

2. Is your adolescent involved in any organized social activities ( e.g. sports, scouts, music)? _____

_____

3. What activities does your adolescent prefer to do?_____

_____

4. Do you feel uncomfortable about any of your adolescent's activities ? ____ Yes ____ No

If yes, please explain:_____

_____

## School History

1. Has your adolescent ever been held back a grade?_____

2. What are the grades your adolescent receives at school?_____

3. Do you feel your adolescent is doing the best he/she can at school?_____

4. Are there any behavior problems at school? ___ Yes ____ No

If yes, please explain:_____

_____

5. What is your adolescent's best subject? _____

Worst subject?_____

6. How many schools has your adolescent attended?_____

## Discipline

1. How do you discipline your adolescent? Describe:

Father:_____

Mother:_____

Other adults in family:_____

2. Are there differences between father and mother with regard to discipline? ____ Yes ____ No

If yes, please explain:_____

_____

Have these differences been a source of strain in the family? ____ Yes ____ No

3. Who usually disciplines the adolescent?_____

4. Does the adolescent prefer one parent over the other? ____ Yes ____ No

If yes, whom?_____

## Medical History

Check the age(s) at which this adolescent had any of the following health problems. If she/he has never had the problem, check the box in the "Never" column. If the health problem is still continuing or is a current concern, check the box in the "Current Concern" column. More than one category may be checked.

| | Never | O-6 Months | 7-12 Months | 1-2 Years | 2-4 Years | 4-6 Years | Since 6 Years | Current Concern |
|---|---|---|---|---|---|---|---|---|
| High fever (over 103°) | | | | | | | | |
| Seizures (convulsions) | | | | | | | | |
| Rashes or skin problems | | | | | | | | |
| Meningitis | | | | | | | | |
| Asthma | | | | | | | | |
| Food allergies | | | | | | | | |
| Other allergies | | | | | | | | |
| Pneumonia | | | | | | | | |
| Anemia (low blood count) | | | | | | | | |
| Heart problems | | | | | | | | |
| Kidney or urinary problems | | | | | | | | |
| Bowel problems | | | | | | | | |
| Trouble with vision | | | | | | | | |
| Trouble with hearing | | | | | | | | |
| Lack of weight gain | | | | | | | | |
| Poisoning or medication overdose | | | | | | | | |
| Serious injury | | | | | | | | |
| Hospitalization | | | | | | | | |
| Surgery | | | | | | | | |

Other important illnesses (list):_____

_____

Medication used over a long period of time (list):_____

Current medication:_____

In general, this adolescent's heath has been:

_____ excellent (is rarely sick, when sick recovers very quickly)
_____ good (is not often sick or injured, illnesses are fairly short-lived)
_____ fair (frequently sick or injured, illnesses often linger or recur)
_____ poor (chronically ill)

Name of physician:_____

## Adolescent's Strengths

Please mark those strengths that you have observed in your adolescent:

| | Often True | Sometimes True | Seldom True | Cannot Say |
|---|---|---|---|---|
| Outgoing | | | | |
| Self-confident | | | | |
| Seems happy | | | | |
| Friendly | | | | |
| Enjoys new experiences or activities | | | | |
| Even disposition or steady moods | | | | |
| Expresses feelings | | | | |
| Affectionate | | | | |
| Kind or sympathetic to others | | | | |
| Shares | | | | |
| Can compromise | | | | |
| Follows rules easily | | | | |
| Is forgiving | | | | |
| Stands up for self when appropriate | | | | |
| Tolerates criticism | | | | |
| Recovers easily after disappointment | | | | |
| Is appropriately cautious | | | | |
| Creative | | | | |
| Plays gently with smaller children or animals | | | | |
| Good sense of humor | | | | |
| Creative | | | | |

Family Illnesses/Disorders

| | Mother's Family | Biological Mother | Biological Father | Father's Family |
|---|---|---|---|---|
| Anxiety disorders | | | | |
| ADHD or ADD | | | | |
| Mental retardation | | | | |
| Seizure disorder | | | | |
| Depression | | | | |
| Schizophrenia | | | | |
| Other psychiatric disorder | | | | |
| Learning difficulties | | | | |
| Behavioral problems | | | | |
| Alcoholism or drug dependence | | | | |

Inherited conditions (e.g. Huntington's Chorea, Sickle Cell Anemia): _____

_____

Other significant family illness: _____

_____

## Parent's History

Biological Father:
Birth date: _____
Ethnic origin: _____ Occupation: _____
Place of Employment: _____
Date of marriage: _____ If separated, divorced, widowed, previously married, please specify and give dates: _____

_____

Education (Check appropriate categories and specify year and degree reached in each category):

| Elementary | High School | Technical Training | College | Graduate School | Other (Specify) |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |

Biological Mother:
Birth date: _____
Ethnic origin: _____ Occupation: _____
Place of Employment: _____
Date of marriage: _____ If separated, divorced, widowed, previously married, please specify and give dates: _____

_____

Education (Check appropriate categories and specify year and degree reached in each category):

| Elementary | High School | Technical Training | College | Graduate School | Other (Specify) |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |

## Parent's Marital/Significant Other Relationship

1. Would you describe your present marital/significant other relationship as (check one):

_____ smooth

_____ with occasional difficulties

_____ with frequent difficulties

_____ failure

2. Describe any significant relationship problems now, or in the past:_____

_____

_____

_____

_____

3. Have you sought outside help with regards to relationship problems? ____ Yes ____ No

If yes, please give details:_____

_____

_____

_____

4. Does any parent/caregiver have difficulties with nervousness, anxiety, or depression? ____ Yes ____ No

If yes, please explain:_____

_____

_____

5. Does any parent/caregiver have difficulties with anger, e.g. losing temper easily, verbally abusive, being violent when angry? ____ Yes ____ No If yes, please explain:_____

_____

_____

Family Counseling Center
Adolescent Questionnaire (Ages 11 to 17)
**For Adolescent to Complete**

Please answer all questions as best as you can. Honest answers will allow us to have a better understanding of you. Feel free to ask your counselor if you need help with any part of the form.

Name:_____

What would you like the Center to help you with at this time?:_____

_____

In school:

| Yes | No | |
|---|---|---|
| ___ | ___ | Are you getting poor grades? |
| ___ | ___ | Are you having trouble getting along with other students? |
| ___ | ___ | Are you having trouble getting along with teachers? |
| ___ | ___ | Do you have poor attendance? |
| ___ | ___ | Were you ever suspended? If yes, how many times? _____ |
| ___ | ___ | Have you ever been held back a grade? |

In social situations do you:

| Yes | No | |
|---|---|---|
| ___ | ___ | Feel like avoiding your classmates/peers? |
| ___ | ___ | Feel that your classmates/peers want to avoid you? |
| ___ | ___ | Prefer to be with friends much younger than you? |
| ___ | ___ | Prefer to be with friends older than you? |
| ___ | ___ | Prefer to be alone? |
| ___ | ___ | Do things you are uneasy about just to fit in? |

What do you do for fun?_____

In your family, do you get along with your:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ___ | ___ | Mother | ___ | ___ | Step-mother |
| ___ | ___ | Father | ___ | ___ | Brothers |
| ___ | ___ | Step-father | ___ | ___ | Sisters |
| ___ | ___ | Others_____ | | | |

With whom do you get along best?_____

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Chemical use:

Please complete the following if you have used chemicals in the past year. Check the chemical(s) you have used and check how often you used the chemical(s).

| | Daily | 2-3 Times Per Week | Weekly | Monthly | On Special Occasions | Only Once Or Twice |
|---|---|---|---|---|---|---|
| Tobacco | | | | | | |
| Substance Sniffed | | | | | | |
| Alcohol | | | | | | |
| Illegal drugs | | | | | | |

| Yes | No | |
|---|---|---|
| ___ | ___ | Have you used more than one chemical at the same time in order to get high? |
| ___ | ___ | Do you avoid family activities so you can use? |
| ___ | ___ | Do you have a group of friends who also use? |
| ___ | ___ | Do you use to improve your emotions such as when you feel sad or depressed? |

Have you ever been upset by what someone has done to you?

| Yes | No | |
|---|---|---|
| ___ | ___ | Physically |
| ___ | ___ | Emotionally |
| ___ | ___ | Sexually |

Have you recently or do you currently experience the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ___ | ___ | Suicidal thoughts | ___ | ___ | Difficulty eating |
| ___ | ___ | Suicide plans | ___ | ___ | Depression, loneliness, or hopelessness |
| ___ | ___ | Suicide attempts and/or self-inflected injury | ___ | ___ | Crying often |
| | | | ___ | ___ | Frightening dreams or thoughts |
| ___ | ___ | A tendency to be shy or sensitive | ___ | ___ | A strong dislike of criticism |
| ___ | ___ | Often annoyed by little things | ___ | ___ | Difficulty completing tasks |
| ___ | ___ | A frequent loss of temper | ___ | ___ | Violent or destructive behavior |
| ___ | ___ | Difficulty expressing feelings | ___ | ___ | Difficulty remembering |
| ___ | ___ | Nervousness, anxiety, or worry | ___ | ___ | Difficulty concentrating |
| ___ | ___ | Difficulty relaxing | ___ | ___ | Mental confusion |
| ___ | ___ | Difficulty making decisions | ___ | ___ | Thoughts about hurting or killing others |
| ___ | ___ | Difficulty sleeping | | | |

Do you have worries about your health or appearance?_____

_____

What do you like about yourself? What are your strengths?_____

_____