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ADOLESCENT CLIENT QUESTIONNAIRE

Ages 17 and Under
(To Be Filled Out By Parent/Guardian)

Today's Date_____
Child's Name_____ Birthdate_____
Age_____ Grade_____ Gender_____
How were you referred_____ May I thank this person for the referral____

Home Address_____
_____

Name of Person Completing This Form_____
Relationship To Child_____

Relationship Status of Parents:
__Never Married __Married __Divorced __Separated __Widow/Widower

Mother's Name and Address_____
Father's Name and Address_____
Stepparent's Name and Address _____

School Name_____ School District_____
Pediatrician/Physician_____Phone_____
Address_____

Adolescent Client's Phone_____ Circle one: Cell Home
May I use this number to leave voicemail/text messages if I need to contact client_____

Mother's Phone _____ Circle one: Cell Home Work
Ok to leave voicemails/texts?_____
Mother's Place of Employment_____
Mother's Email_____ Ok to email?_____

Father's Phone_____ Circle one: Cell Home Work
Ok to leave voicemails/texts?_____
Father's Place of Employment_____
Father's Email_____ Ok to email?_____

Name of person responsible for the bill_____

List All People Living In Client's Household:

Name	Relationship to Child	Age	Occupation/Grade

Primary Language_____
Other languages spoken in the home_____
Race/ethnicity_____ Religion_____

Why are you seeking professional services for your child at this time? Briefly describe your child's difficulties.

_____
_____
_____
_____

How long has this problem been a concern_____
When was it first noticed_____
What seems to help_____
What seems to make it worse_____

Has your child ever received psychological evaluation/treatment/counseling_____
If so, when and with whom_____
What was the focus of treatment_____
Is the child on any medication at this time (please provide name and dosage):

_____
_____
_____

Checklist of Concerns About Your Child

On the following pages please circle any concerns that apply, and feel free to add more information next to the concern.

ABUSE
AGGRESSION
ANGER
ANXIOUS/WORRIES
ATTENTIONAL ISSUES
ARGUES
BULLIES/IS BULLIED
CRUEL TO ANIMALS
CONFLICTS WITH FAMILY
CONFLICTS WITH FRIENDS
COMPLAINS
COMPULSIONS
CRIES EASILY
DIFFICULTIES WITH NEW MARRIAGE/FAMILY
DEPENDENT
DEPRESSED
DEVELOPMENTAL DELAYS
DISRUPTIVE
DISTRACTIBLE
DRUG/ALCOHOL USE
EATING PROBLEMS
FATIGUE
FEARS/PHOBIAS
FRIENDSHIPS
GENDER IDENTITY
HEADACHES
HYPERACTIVE
IMMATURE
IMPULSIVITY
IRRITABILITY
LACKS ORGANIZATION
LACKS RESPECT FOR AUTHORITY
LEARNING DISABILITY
LEGAL PROBLEMS
LONELINESS
LOW FRUSTRATION TOLERANCE
LYING

MOOD SWINGS
NERVOUSNESS
NIGHTMARES
OBSESSIONAL THOUGHTS
PANIC ATTACKS
RISK TAKING
SCHOOL FAILURE
SELF ESTEEM
SELF HARM
SEPARATION DIFFICULTIES
SEXUAL ACTIVITY
SLEEP
SHYNESS
SMOKING
SUICIDAL THOUGHTS OR ATTEMPT
TEMPER
TICS
WEIGHT/BODY IMAGE
WITHDRAWAL

What are your goals/expectations of treatment for your child_____
_____
_____

Please describe any significant educational history. For example, academic difficulties, special needs, school moves, etc.

_____
_____
_____
_____

Please describe any significant developmental history. For example, pregnancy and delivery complications, eating/sleeping problems, developmental delays, etc.

_____
_____
_____
_____

Please list all significant childhood illnesses, hospitalizations, head injuries, surgeries, medical diagnoses, etc. Please include the age of child at the time.

_____
_____

Family Mental Health History: (Please indicate which family member)

Anxiety_____
Depression_____
Bipolar_____
ADHD_____
Learning Disability_____
Substance Abuse_____
Suicide_____
Schizophrenia_____

What activities does your child participate in_____
_____

Which disciplinary techniques do you usually use when your child behaves inappropriately?
_____
_____

Is there anything else that does not appear on this form that would be important for me to know? If so, please describe in the space below.