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Teen/ Young Adult History Questionnaire

Please complete the following questionnaire to give me a general understanding of various aspects of your child's life. This information will be very helpful in determining the types of intervention that your child may need.

Name: _____ Birth date: _____Age:_____ Driver's License #_____

Name of the parent/guardian: _____

Home Address: _____

City: _____ State:_____ Zip Code:_____ Today's date:_____

Home Phone: ( ) ____- _____Cell Phone: ( ) ____- _____ e-mail:_____

Is it OK to receive email regarding appointments yes/no

it OK to leave a voicemail at home____ mobile____ work____ yes/no

Emergency Contact's name: _____ Phone: ( ) ____- _____

Child's Birthplace: _____ Religious affiliation:_____ Pronouns: she/her he/him they/them

Current Reason For Seeking Therapy or Evaluation:

_____
_
_____

List three issues/conditions that concern you most:

- _____
- _____
- _____

When did you first notice these issues/conditions?

_____
_____

What have you/they already tried to resolve these issues/conditions?

_____
_____

What has helped? What has not been helpful?

_____
_____

What worries you most if things stay the way they are?

_____
_____

List the most stressful things in their life that are affecting them right now:

- _____
- _____
- _____

What would you like to see happen as a result of therapy?

_____
_____

Therapy History:

Have they previously seen a therapist? □yes □ no
If yes, what did they find **most helpful** in therapy?

_____
_____

What did they find **least helpful** in therapy?

_____
_____

Family History:

Are both parents living? □yes □ no
Are parents: □ married □ divorced □ remarried

How does your child get along with their parents?

_____
_____
_____

Do they have any: □ siblings □ step-siblings
Do they get along with them? □yes □ no Why or why not?

_____
_____
_____

If parents are divorced, what is their living arrangement?

_____
_____

Is there anyone else close to your child, that is influential in their life, that we should know about?

_____
_____

Please check any concerns that your family is currently experiencing:

☐ fighting	☐ feeling distant	☐ loss of fun	☐ lack of honesty
☐ physical fights	☐ financial problems	☐ death of a family member	☐ abuse/neglect
☐ housing problems	☐ job change/loss	☐ alcohol use	☐ drug use
☐ parent having affair	☐ divorce/separation	☐ issues with remarriage	☐ new sibling
☐ health issues	☐ other_____	☐ other_____	☐ other_____

Social History:

List some of the good qualities you like about your child:

_____

_____

Do they make friends easily? □yes □ no

Do you consider them socially (check all that apply): □ outgoing □ shy □ leader □ follower □ loner □ socially popular □ comfortable with their social group □ an outcast □ picked on/ teased

Have they ever been bullied? □yes □ no If so, by whom?

_____

_____

Do they have a best friend? □yes □ no

Are they happy with the amount of friends they have? □yes □ no

Are you happy with their friends? □yes □ no

To what extent do they seem to rely on their friends for support?

_____

_____

Are they involved in any organized social activities (e.g. sports, scouts, music)? □yes □ no

If so, what?_____

_____

What do they like to do in their free time?

_____

_____

Are they dating? □yes □ no Are they currently in a relationship? □yes □ no

Are they sexually active? □yes □ no If yes, do they use birth control? □yes □ no

Do they consider themself: □ heterosexual □ gay □ lesbian □ bisexual □ transgender □ questioning

Are theyworking? □yes □ no What do they do?_____

How many hours a week?_____

Do they have a history of trauma? (i.e. sexual assault, been in an accident, witnessed violence, history of physical abuse, emotional abuse) □yes □ no

Please explain:

School History:

Current grade_____ School (name)_____ □ public □ private □ other
Do they like school? □yes □ no Do they attend school regularly? □yes □ no
What are their current grades:_____

Last grade completed:_____ □ High School Diploma □ GED □ Vocational Training □ College_____

Do they have any learning challenges? (ADHD, Learning Disability, Dyslexia, etc.)_____
_____

Do they currently or have they had an: □ IEP □ 504 □ GATE Program

Lifestyle Behaviors:

Do they have any current physical concerns or chronic health conditions? □yes □ no
Please describe:_____
_____

What medications do they take, including vitamins, natural products, etc:_____
_____

Do they take their prescribed medications daily? □yes □ no
Do you suspect they may misuse any prescription medication? □yes □ no

How would you describe their current physical health? □ very healthy □ mostly healthy □ moderately healthy
□ often sick □ almost always sick

How well do they sleep: □ very well □ pretty well □ ok □ poorly
They sleep: □ too much □ not enough □ have trouble falling asleep □ have trouble staying asleep

How often do they exercise: □ daily □ couple times a week □ occasionally □ rarely
What do they do for exercise?_____

Do they drink caffeine? □yes □ no If so, what (soda, coffee, etc.)?_____

Do you have any concerns around their eating habits? □yes □ no If yes, please describe:_____
_____

How do they feel about their body?
_____
_____

Individual Concerns:
Please check any they have experienced in the past 6 months.

SYMPTOM	NONE	MILD	MOD	SEVERE	**SYMPTOM**	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					SOCIAL ISOLATION				
SLEEP DISTURBANCES					PARANOID THOUGHTS				
PROBLEMS AT HOME					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/ PURGING					LOW ENERGY				
LONLINESS					EXCESSIVE WORRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/ INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
CUTTING					RACING THOUGHTS				
IMPULSIVITY					RESTLESSNESS				
NIGHTMARES					DRUG USE				
HOPELESSNESS					ALCOHOL USE				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					OBSESSIVE THOUGHTS				
ANOREXIA					PANIC ATTACKS				
GRIEF					FEELING ANXIOUS				
PHOBIAS					FEELING PANICKY				
HEADACHES					SUICIDAL THOUGHTS				
WEIGHT CHANGES					PAST SUICIDE ATTEMPTS				

Please check items of concern to you:

- ☐ anxiety/nervousness
- ☐ shyness
- ☐ social problems
- ☐ stress
- ☐ anger
- ☐ fear making mistakes
- ☐ explosive temper
- ☐ low energy
- ☐ high energy
- ☐ unhappy most of the time
- ☐ cry too often
- ☐ body image
- ☐ death of a pet
- ☐ sadness
- ☐ difficulties concentrating
- ☐ loneliness
- ☐ low self confidence
- ☐ low self esteem
- ☐ obsessive thoughts
- ☐ unusual thoughts
- ☐ frequent headaches
- ☐ frequent stomachaches
- ☐ frequent illness
- ☐ other_____

Drug/Alcohol History:

Do they currently use alcohol? □yes □ no

If yes, how often? □ daily □ 1-2x weekly □ socially □ occasionally □ rarely

_____

Do they currently smoke marijuana? □yes □ no

If yes, how often? □ daily □ 1-2x weekly □ socially □ occasionally □ they've tried it

Have they ever smoked cigarettes? □yes □ no

Have they ever vaped? □yes □ no

Is there anything else that is important for me to now about your child that has not yet been asked or expressed? If yes please explain below: