Shoreview Mental Health Center LLC
hope · · · wellness · · · peace
P: (651) 348-7240 | F: (651) 348-7265 | www.shoreviewmentalhealth.com
Rice Creek Professional Building | 5985 Rice Creek Parkway | Suite 201 | Shoreview, MN 55126

Adolescent Questionnaire

Ages 12-18

Date: _____

Name: _____ Date of Birth: _____ Age: ___ Gender: _____

Address: _____
_____

Primary phone: _____ Home ☐ Work ☐ Cell ☐ Parent ☐
Secondary phone: _____ ☐ ☐ ☐ ☐

School: _____ Grade: _____

Employer: _____ Occupation: _____

What is the reason for your visit?

How distressing is this for you? (rate 0-10: 0 - not at all, 10 - most distressing): _____

Background Information:

Parents' Names:	Age	Job / Retired	Physical / Emotional / Psychological Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Siblings' Names:	Age	Job	Physical / Emotional / Psychological Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children's Names:	Age	Physical / Emotional / Psychological Problems
_____	_____	_____
_____	_____	_____

Current Living Situation: ☐ House ☐ Apartment ☐ Other: _____

Others Living With You: ☐ Mother ☐ Father ☐ Grandparent(s) ☐ Significant Other: _____
☐ Sibling(s) ☐ Children ☐ Other(s): _____

*All information on this form is considered strictly confidential within the guidelines of the clinic

Check any problems that trouble you in your family:

- ☐ Parent is physically sick
- ☐ Parent has emotional problems
- ☐ Parent has trouble with alcohol/drugs
- ☐ Parents fighting
- ☐ Parents divorcing
- ☐ Problems with Step-Parent
- ☐ Parents never home
- ☐ Can't talk to Parents
- ☐ Parents too strict
- ☐ Parents expect too much
- ☐ Parents disapprove of friends
- ☐ Parents disapprove of activities/music
- ☐ Feeling ignored by Parent(s)
- ☐ Pet dying
- ☐ Sibling is physically sick
- ☐ Sibling has emotional problems
- ☐ Sibling has problems with alcohol/drugs
- ☐ Being physically abused at home
- ☐ Being sexually abused at home
- ☐ Don't want to live at home
- ☐ Family fighting
- ☐ Don't have enough privacy
- ☐ Too many household chores
- ☐ Don't feel close to family
- ☐ Parents disapprove of clothes/appearance
- ☐ Parents favor siblings
- ☐ Other: _____

Issues that concern you:

- ☐ Suicidal thoughts
- ☐ Anxious/worried
- ☐ Bored
- ☐ Confused
- ☐ Cutting/burning self
- ☐ Difficulty being alone
- ☐ Easily distracted
- ☐ Fatigued
- ☐ Guilt feelings/shame
- ☐ Hyperactivity
- ☐ Lonely
- ☐ Mood swings
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Low self esteem
- ☐ Sexual problems
- ☐ Tearful
- ☐ Repeatedly washing hands
- ☐ Anger problems
- ☐ Alcohol use
- ☐ Frequently lying
- ☐ Shy/uneasy with others
- ☐ Unwanted behavior/habits
- ☐ Sleep problems:
  - ☐ At times it takes me over 1 ½ hour to fall asleep
  - ☐ I wake up a lot at night
- ☐ Eating habits:
  - ☐ Restricting
  - ☐ Overeating
  - ☐ Purging/vomiting
  - ☐ Binging
  - ☐ Laxative use for dieting
- ☐ Suicide attempts
- ☐ Attitude issues
- ☐ Sibling problems
- ☐ Count excessively
- ☐ Depressed
- ☐ Disorganized
- ☐ Easily irritated
- ☐ Problems focusing
- ☐ Hearing voices/hallucinations
- ☐ Impulsive
- ☐ Memory/concentration problems
- ☐ Motivation reduced/absent
- ☐ Excessive organization
- ☐ Parent problems
- ☐ Sexual identity concerns
- ☐ Sexually active
- ☐ Unusual thoughts
- ☐ Very concerned about germs
- ☐ Aggressiveness
- ☐ Drug use
- ☐ Perfectionist
- ☐ Unassertive
- ☐ Withdrawn
- ☐ Weight changes
  - ☐ Increase
  - ☐ Decrease

I worry about:

- ☐ Being popular
- ☐ My sibling(s)
- ☐ Money problems
- ☐ Being left out
- ☐ Being bullied
- ☐ My friends
- ☐ Everything
- ☐ Being sick a lot
- ☐ My parents
- ☐ School issues
- ☐ Other: _____

I feel bad about:

- ☐ People putting me down
- ☐ My family
- ☐ My appearance
- ☐ I get angry a lot
- ☐ I have trouble living up to others' expectations
- ☐ I try to please everyone
- ☐ I like to argue/compete with others
- ☐ Being excluded
- ☐ Not saying "no"
- ☐ Others' opinions of me are very important
- ☐ Not having enough friends
- ☐ My grades
- ☐ The way I treat people
- ☐ I get in fights a lot
- ☐ I try to get my own way a lot
- ☐ I think I'm right all the time
- ☐ Myself
- ☐ Other: _____

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Medical History:

Medical concerns in the last year: _____

Chronic illness: _____

Surgeries: _____ Disabilities: _____

Primary Care Provider: _____

Additional prescribing provider(s)? _____

Current medications and reasons prescribed:

_____

Counseling: (current and/or previous)

Dates	Clinic / Therapist	Reason	Helpful? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatric Hospitalizations:

Dates	Hospital / MD	Reason	Helpful? (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Abuse Issues:

Please indicate areas of abuse that **you have experienced**:

☐ Not applicable

	Past	Current
Physical	☐	☐
Sexual	☐	☐
Verbal	☐	☐
Emotional	☐	☐

Please indicate areas of abuse **by you:**

☐ Not applicable

	Past	Current
Physical	☐	☐
Sexual	☐	☐
Verbal	☐	☐
Emotional	☐	☐

Alcohol/Substance Use: Please indicate any substances that you have used (current and/or previous)

	Type	Age at first use	How much and how often?	Last used
Nicotine:	_____	_____	_____	_____
Caffeine:	_____	_____	_____	_____
Alcohol:	_____	_____	_____	_____
Illegal/Street Drugs:	_____	_____	_____	_____
Misused Prescription Drugs:	_____	_____	_____	_____
Misused Over-the-Counter Drugs:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

	Y	N	Not applicable
Have there been any undesirable results of your chemical abuse? (Low job/school performance, physical or relationship problems, DWI, etc.)	☐	☐	☐
Have you ever been concerned about your own chemical abuse?	☐	☐	☐
Have others expressed concern about your chemical abuse?	☐	☐	☐
Do others who are close to you abuse alcohol or drugs? If yes, who: _____	☐	☐	☐
Have you ever attended a self-help or support group? (Such as AA, NA, AlAnon, ACA)	☐	☐	☐
Are you currently attending a self-help or support group? If yes, name of group: _____	☐	☐	☐

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Social History:

How many close friends do you have right now? _____
Approximately how often do you have contact with these friends? (Please select one)
☐ Daily ☐ 3-5 times per week ☐ Once a week ☐ 2 times per month ☐ Once a month

What are your hobbies / interests? _____

Please check the problems that trouble you:

- ☐ Being uncomfortable with people
- ☐ Being criticized by others
- ☐ Being suspicious of others
- ☐ Being taken advantage of by friends
- ☐ Worrying about getting/being pregnant
- ☐ Thinking about sex too often
- ☐ Worried about same-sex attraction
- ☐ Sexual abuse
- ☐ Feeling pressured to do something against my will
- ☐ Having problems with boyfriend/girlfriend
- ☐ Other: _____
- ☐ Being involved with pornography (movies, magazines, computer, etc.)
- ☐ Being uncomfortable with the opposite gender
- ☐ Not fitting in with peers
- ☐ Not having enough close friends
- ☐ Feeling inferior
- ☐ Not knowing enough about sex
- ☐ Worrying about sex
- ☐ Feeling used or being pressured to have sex
- ☐ Physical abuse

Educational Issues:

Are you having trouble with: ☐ Grades ☐ Skipping class ☐ Absences ☐ Teacher relationships
☐ Learning disabilities ☐ Other
Please explain: _____

Job Issues:

Please list your last three jobs outside of the home:

Position	Responsibilities	Start Date	End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal:

Religious / Spiritual Involvement: _____
Is religion/spirituality important to you? _____

Cultural / Ethnic Background: _____

Is there anything else you would like us to know about you?

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Name_____Date_____

The Burns Anxiety Inventory

Instructions: The following is a list of symptoms that people sometimes have. Put a check in the space to the right that best describes how much that symptom or problem has bothered you *during the past week*:

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot

	Anxious Feelings	0	1	2	3
1.	Anxiety, nervousness, worry, or fear.				
2.	Feeling that things around you are strange, unreal or foggy.				
3.	Feeling detached from all or part of your body.				
4.	Sudden unexpected panic spells.				
5.	Apprehension or a sense of impending doom.				
6.	Feeling tense, stressed, "uptight," or on edge.				
	Subtotal from Section I				
	Anxious Thoughts	0	1	2	3
7.	Difficulty concentrating.				
8.	Racing thoughts or having your mind jump from one thing to the next.				
9.	Frightening fantasies or daydreams.				
10.	Feeling that you're on the verge of losing control.				
11.	Fears of cracking up or going crazy.				
12.	Fears of fainting or passing out.				
13.	Fears of physical illnesses or heart attacks or dying.				
14.	Concerns about looking foolish or inadequate in front of others				
15.	Fears of being alone, isolated, or abandoned.				
16.	Fears of criticism or disapproval.				
17.	Fears that something terrible is about to happen.				
	Subtotal from Section II				
	Physical Symptoms	0	1	2	3
18.	Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19.	Pain, pressure, or tightness in the chest.				
20.	Tingling or numbness in the toes or fingers.				
21.	Butterflies or discomfort in the stomach.				
22.	Constipation or diarrhea.				
23.	Restlessness or jumpiness.				
24.	Tight, tense muscles.				
25.	Sweating not brought on by heat.				
26.	A lump in the throat.				
27.	Trembling or shaking.				
28.	Rubbery or "jelly" legs.				
29.	Feeling dizzy, light-headed, or off balance.				
30.	Choking or smothering sensations or difficulty breathing.				
31.	Headaches or pains in the neck or back.				
32.	Hot flashes or cold chills.				
33.	Feeling tired, weak, or easily exhausted.				
	Subtotal from Section III				
	Combined Total				

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot

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Name_____Date_____

The Burns Depression Checklist

Instructions: Put a check in the space to the right to indicate how much you have experienced each symptom *during the past week, including today*. Please answer all 25 items.

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot **4** = Extremely

	Thoughts and Feelings	0	1	2	3	4
1.	Feeling sad or down in the dumps					
2.	Feeling unhappy or blue					
3.	Crying spells or tearfulness					
4.	Feeling discouraged					
5.	Feeling hopeless					
6.	Low self-esteem					
7.	Feeling worthless or inadequate					
8.	Guilt or shame					
9.	Criticizing yourself or blaming others					
10.	Difficulty making decisions					
	Subtotal from Section I					
	Activities and Personal Relationships	0	1	2	3	4
11.	Loss of interest in family, friends, or colleagues					
12.	Loneliness					
13.	Spending less time with family or friends					
14.	Loss of motivation					
15.	Loss of interest in work or other activities					
16.	Avoiding work or other activities					
17.	Loss of pleasure or satisfaction in life					
	Subtotal from Section II					
	Physical Symptoms	0	1	2	3	4
18.	Feeling tired					
19.	Difficulty sleeping or sleeping too much					
20.	Decreased or increased appetite					
21.	Loss of interest in sex					
22.	Worrying about your health					
	Subtotal from Section III					
	Suicidal Urges	0	1	2	3	4
23.	Do you have any suicidal thoughts?					
24.	Would you like to end your life?					
25.	Do you have a plan for harming yourself?					
	Subtotal from Section IV					
	Combined Total					

0 = Not at All **1** = Somewhat **2** = Moderately **3** = A Lot **4** = Extremely

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Patient Name: _____ D.O.B.: _____ Date: _____

GAD-7 QUESTIONNAIRE

How often during the past 2 weeks have you felt bothered by:

1. Feeling nervous, anxious, or on edge?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

2. Not being able to stop or control worrying?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

3. Worrying too much about different things?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

4. Trouble relaxing?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

5. Being so restless that it is hard to sit still?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

6. Becoming easily annoyed or irritable?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

7. Feeling afraid as if something awful might happen?
0 = not at all
☐ 1 = several days
2 = more than half the days
3 = nearly everyday

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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Patient Name: _____ D.O.B.: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

ADD COLUMNS FOR TOTAL SCORE _____ + _____ +_____ +_____

TOTAL SCORE: _____

NOTE: If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult