Adolescent Individual Intake Questionnaire

** indicates a required field*

Personal History

*** What is the reason you are coming in for counseling? Is there something specific, such as a particular event? If this is due to a specific event, when did it start or happen? How is your life affected by this issue? 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
- [ ] Anxiety/Worry
- [ ] Parents
- [ ] Friends
- [ ] Sex
- [ ] School
- [ ] Substance Use
- [ ] Legal
- [ ] Anger Issues
- [ ] Suicidal Thoughts
- [ ] Trouble eating food

School and Social Functioning

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

When did/do you attend class?

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 (i.e., resource program, gifted programs)?

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

- Yes
- No

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
- N/A

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

- Yes
- No

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

- Yes
- No, I don't use any nicotine products.

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

- Yes
- No

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

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

- Yes
- No

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

- Yes
- No
- N/A

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, and indicate when you experienced them.

- [ ] Headaches
- [ ] Restlessness
- [ ] Dizziness
- [ ] Pain
- [ ] Excessive anger
- [ ] Less need for sleep
- [ ] Excess energy
- [ ] Elated mood
- [ ] Excessive spending
- [ ] Racing thoughts
- [ ] Feeling irritable
- [ ] Feeling wired
- [ ] Mood swings
- [ ] Grandiose thoughts
- [ ] Impulsive behavior
- [ ] Confusion
- [ ] Alcohol craving
- [ ] Drug craving
- [ ] Eating problems
- [ ] Weight gain
- [ ] Weight loss
- [ ] Loss of appetite
- [ ] Difficulty getting to sleep
- [ ] Appetite changes
- [ ] Difficulty staying asleep
- [ ] Frequent nightmares
- [ ] Low energy
- [ ] Unable to have fun
- [ ] Decreased pleasure
- [ ] Feeling worthless
- [ ] Feeling hopeless

- [ ] Feeling isolated
- [ ] Suicidal thoughts
- [ ] Suicidal plans
- [ ] Attempted suicide
- [ ] Crying frequently
- [ ] Anxiety
- [ ] Frequent worrying
- [ ] Fears
- [ ] Panic attacks
- [ ] Avoiding places of situations due to fear or panic/anxiety
- [ ] Concentration problems
- [ ] Feel that others are plotting against you
- [ ] Constant suspicion or distrust
- [ ] Hearing voices that others do not hear
- [ ] Seeing things others do not see
- [ ] Physical abuse
- [ ] Sexual abuse
- [ ] Emotional/verbal abuse
- [ ] Sexual problems
- [ ] Relationship problems
- [ ] Family conflict
- [ ] Fears of losing control
- [ ] Unwanted thoughts or behaviors
- [ ] Feeling the need to do/repeat things
- [ ] Obsessive/repetitive thoughts
- [ ] Unusual thoughts
- [ ] Strange experiences
- [ ] Thoughts of someone physically harming you
- [ ] Thoughts of physically harming someone
- [ ] Violent or aggressive behavior

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?**

- ○ Yes
- ○ No

If applicable, list all psychotropic medications you are currently taking, for how long, and for what reason. What is the dosage of each? What time of day do you take it (morning, evening, bedtime)? Does it help?

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?**

- ☐ If yes, when?
- ☐ If yes, how would you end your life?
- ☐ No, I have never had suicidal thoughts.

*** Have you ever attempted suicide? Please list all attempts and your age when each happened, starting from the most recent event to the oldest event.**

- ☐ If yes, when?
- ☐ If yes, how did you do it?
- ☐ No, I have never attempted suicide.

*** Have you ever been hospitalized for a psychiatric issue? If yes, please describe why, when, and the length of your stay.**

- [ ] Yes
- [ ] No, I have never been hospitalized for a psychiatric reason

*** Do any family members struggle with the following challenges? Please specify which family member.**

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

Family History

*** Please describe your relationship with your mother(s)/Guardian/Caretaker.**

*** Please describe your relationship with your father(s)/Guardian/Caretaker.**

*** Do you have siblings? If so, please describe your relationship with them.**

- Yes
- No

*** 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" (e.g., grandparent, aunt, uncle, friend, cousin, teacher, etc.)?**

*** What else would you like me to know?**