CEDAR CREEK ASSOCIATES

ADOLESCENT QUESTIONNAIRE (To be filled out by the Adolescent)

PERSONAL INFORMATION

Name: _____ Date: _____

Age: _____

Please explain why you are seeking treatment: _____

_____

Please list everyone living in your home:

Name	Age	Relationship	Quality of Relationship

Please list other immediate family members not currently living in the your home. Who are you close to:

Name	Age	Relationship	Quality of Relationship

EDUCATIONAL INFORMATION:

What are your favorite school activities? _____

_____

What kind of grades do you typically make? _____

MEDICAL INFORMATION:

Do you have any medical conditions? _____ Yes _____ No

Please explain: _____

_____

Please check any concerns or events from the list below:

Your weight or diet: _____ Have you ever been unconscious from a head injury?

Do you drink caffeine (soda, tea, coffee)? ____ Have you had previous counseling or testing?

Have you ever been hospitalized? _____ Have you tried or used drugs, tobacco, or alcohol?

Have you ever been neglected, traumatized, or abused?

Have you ever been the victim of a crime? : _____ Yes _____ No

SOCIAL/RECREATIONAL INFORMATION:

What are your hobbies and interests: _____

How well do you get along with peers? _____

Do you have a best friend? _____

PRESENTING PROBLEM:

How severe are these concerns to you? ____ Mild ____ Severe ____ Extremely severe

How severe are these concerns to your parent: ____ Mild ____ Severe ____ Extremely severe

When did the problem(s) begin? _____

What have you done to try and solve the problems? _____

Please check any issues you are having:

____	Tiredness	____	Difficulty sleeping	____	Increased tears
____	Argues a lot	____	Loss of interest in activities	____	Nervousness
____	Irritability	____	Withdrawal from others	____	Conflicts
____	Worry	____	Changed eating habits	____	Destructive
____	Thoughts of hurting self	____	Thoughts of suicide	____	Poor attention
____	Aggressive behavior	____	Thoughts of hurting others	____	Nightmares
____	Loss of appetite	____	Grades have dropped	____	Over sleeping
____	Over-eating	____	Confusion	____	Can't focus
____	Poor concentration	____	Memory problems	____	Depressed
____	Increased anxiety	____	Panic attacks	____	Feel paranoid
____	Illness or injury	____	Family moved	____	Friend moved
____	Sibling left home	____	New family member	____	Parent left home
____	Loved one died	____	Experienced or witnessed violence	____	Parents divorced
____	Child moved into/away from family				

Other major loss or event: _____

Thank you for providing this information. Your therapist will be happy to answer questions and address your concerns about these questions.