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**ADOLESCENT QUESTIONNAIRE**

Ages 13-18

**\*\*\*THIS FORM TO BE FILLED OUT BY ADOLESCENT\*\*\***

This form will assist your therapist in knowing about you and will be kept confidential. Please complete all seven (7) pages.  
**Print clearly.**

**CLIENT DEMOGRAPHICS**

Client **Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Birth date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** Female Male

**PRESENTING PROBLEM**

1. Describe the **problems you are having** and **when they began:** \_\_\_\_\_

\_\_\_\_\_

2. **What has contributed** to this difficulty? \_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

1. List allergies, serious illnesses, surgeries, injuries, hospitalizations: \_\_\_\_\_

\_\_\_\_\_

2. List both **prescription** and **over-the-counter medications** presently used for physical conditions:

\_\_\_\_\_

3. My over-all **general health** is: \_\_\_Excellent \_\_\_Good \_\_\_Fair \_\_\_Poor

4. What **physical illnesses** run in your family? \_\_\_\_\_

\_\_\_\_\_

5. What is the name of your **Doctor/Pediatrician?** \_\_\_\_\_

**EDUCATIONAL HISTORY**

1. What is the highest **grade you have completed?** \_\_\_\_\_

2. Do you have any **problems in school?** YES NO If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

3. Have you ever **repeated** or **skipped** a grade? YES NO Which one? \_\_\_\_\_

4. Have you ever **dropped out, been expelled, or been suspended?** Which one? \_\_\_\_\_

What happened? \_\_\_\_\_

\_\_\_\_\_

- 5. How has your **attendance** been?                    \_\_\_Excellent    \_\_\_Good            \_\_\_Fair            \_\_\_Poor
  - 6. What are your **grades** like? \_\_\_\_\_ Have they changed a lot?    YES    NO
  - 7. Do you have **learning difficulties** or attend **special classes**?                    YES    NO
  - 8. Have you ever had **psychological testing**?                    YES    NO
  - 9. What are your **extra-curricular activities**? \_\_\_\_\_
- 

**OCCUPATION**

- 1. Where do you **work**? \_\_\_\_\_ **What do you do?**  
\_\_\_\_\_
- 

**LEGAL HISTORY (in regards to child or any family member)**

- 1. Have you **ever been involved** with the legal system (criminal, divorce, custody, civil, etc.)?    YES    NO    If so, in what way?  
\_\_\_\_\_  
\_\_\_\_\_
- 2. Are you **currently involved** with the legal system (criminal, divorce, custody, civil, etc.)?    YES    NO    If so, in what way?  
\_\_\_\_\_  
\_\_\_\_\_
- 3. Do you have any criminal or civil **cases pending**?    YES    NO
- 4. Do you currently have a **probation/parole officer**?    YES    NO    If so, who? \_\_\_\_\_
- 5. Do you anticipate any **involvement** with the legal system **in the future**?    YES            NO

**TREATMENT HISTORY**

- 1. Have you **been in counseling** before?    YES            NO            If so, with whom? \_\_\_\_\_
- 2. What was the **primary issue**? \_\_\_\_\_  
When? \_\_\_\_\_ For how long? \_\_\_\_\_ What was the outcome?  
\_\_\_\_\_
- 3. Have you ever been **hospitalized for emotional problems** or for **alcohol/drug treatment**?    YES            NO  
If so when? \_\_\_\_\_ Where? \_\_\_\_\_ What was the outcome?  
\_\_\_\_\_
- 4. What **medications** have you taken **in the past** for **emotional or mental problems**? \_\_\_\_\_  
\_\_\_\_\_
- 5. What medications are you **currently taking** for emotional or mental problems? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6. Is there a **history of mental illness** in your family? If so, please explain \_\_\_\_\_

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**SOCIAL HISTORY**

1. What are your major **strengths**? \_\_\_\_\_  
\_\_\_\_\_
2. What are your major **weaknesses**? \_\_\_\_\_  
\_\_\_\_\_
3. From whom do you get **emotional support**? \_\_\_\_\_
4. Do you have **friends**?            YES      NO
5. How do you **get along with** those friends? \_\_\_\_\_  
\_\_\_\_\_
6. Has there been a **change** in your circle of friends lately?    YES      NO
7. Do your friends tend to **get into trouble**?            YES      NO
8. Do you **belong to a gang**?            YES      NO
9. Do any of your **friends belong to a gang**?            YES      NO
10. What have been the **losses, changes, crises, and transitions** in your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Do you have a **belief system** (cultural, moral, spiritual, religious, etc.) which influences your life? Please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Is there **anything about your lifestyle** (or the family's) that would be **helpful for your counselor to know**?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

1. ABOUT YOUR HOUSEHOLD

<u>Name</u>	<u>Age</u>	<u>Relationship to You</u>	<u>How do you get along?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. **Important people in your life** (immediate family/relatives/significant others)

<u>Name</u>	<u>Age</u>	<u>Relationship to You</u>	<u>How do you get along?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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3. Do you **live with your parents**? YES NO Have you **ever lived away** from your parents? YES NO  
Under **what circumstances**? \_\_\_\_\_

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4. Do you have any brothers/sisters, step-brothers/sisters, or half-brothers/sisters who do **not live with you**? YES NO  
5. Your experiences while growing up can affect your life. What **experiences and events** (discipline, favoritism, trauma, affection, lack of attention, etc.) have been **important in your life**? \_\_\_\_\_

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6. Please list your **present and past boyfriend(s)/girlfriend(s)**.

<u>First Name</u>	<u>Time Together</u>	<u>Reason for Ending Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PHYSICAL DEVELOPMENT

1. Please **complete/check** the following:

____ Height	____ Underarm hair
____ Weight	____ Menstruation (female)
____ Build (light, average, heavy)	____ Voice change (male)
____ Breast development (female)	____ Beard (male)
____ Genital hair	____ Acne

### SEXUAL HISTORY

1. **Sex Education:** \_\_\_\_ Home; \_\_\_\_ School; \_\_\_\_ Friends

2. Are you **currently sexually active**? YES NO Single Partner \_\_\_\_\_ Multiple Partners \_\_\_\_\_  
Same Sex Partner \_\_\_\_\_ Both Sex Partners \_\_\_\_\_

3. Do you **use Condoms**? YES NO Do you **use Birth Control**? YES NO

4. Have you ever **had a STD** (Sexually Transmitted Disease)? YES NO

If so what? \_\_\_\_\_

5. Have you ever been **sexually abused**? YES NO If yes, **by whom** and for what **length of time**? \_\_\_\_\_

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6. Has anyone ever **touched you or talked to you sexually** in a way that made you uncomfortable? YES NO

### CONCERNS

For you or any of the above relationships (household, brothers/sisters, partners), have you or any of those persons **ever experienced any of the following problems**:

<u>Concern</u>	<u>Person(s) Who Experienced This</u>
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Mental Illness \_\_\_\_\_

Depression \_\_\_\_\_

Neglect \_\_\_\_\_

Sexual Dysfunction \_\_\_\_\_

Financial Difficulty \_\_\_\_\_

Emotional Abuse \_\_\_\_\_

Physical Abuse \_\_\_\_\_

Sexual Abuse \_\_\_\_\_

Alcohol Abuse \_\_\_\_\_

Drug Abuse \_\_\_\_\_

Other: \_\_\_\_\_

**POSSIBLE ISSUES**

SUBSTANCE ABUSE Do you use **drugs**? Regularly? Occasionally? **How** does your **usage affect your life**?

\_\_\_\_\_

\_\_\_\_\_

What **drugs have you taken**:

\_\_\_\_\_ Depressants: Alcohol, Tranquilizers, Sleeping Pills, Inhalents

\_\_\_\_\_ Stimulants: Cocaine, Crack, Crank, Speed, Diet Pills

\_\_\_\_\_ Stimulants: Caffeine, Nicotine

\_\_\_\_\_ Narcotics: Heroin, Codeine, Morphine

\_\_\_\_\_ Hallucinogens: LSD/Acid, PCP, Peyote, Shrooms

\_\_\_\_\_ Cannabis: Marijuana

\_\_\_\_\_ Other: \_\_\_\_\_

When did you **first use**? \_\_\_\_\_ When did you **last use**? \_\_\_\_\_

SUICIDE/HOMICIDE

Have you **ever had** or **do you have**? Check all that apply.

	<u>Past</u>	<u>Now</u>
Thoughts of hurting yourself?	_____	_____
Thoughts of committing suicide?	_____	_____
Plans to commit suicide?	_____	_____
Attempts to commit suicide?	_____	_____
Threats to commit suicide?	_____	_____
Thoughts of harming someone?	_____	_____
Plans to harm someone?	_____	_____
Attempts to harm someone?	_____	_____
Threats to harm someone?	_____	_____
Actually harmed someone?	_____	_____

DEPRESSION

Have **you ever** or **do you now have**? Check all that apply.

Past

Now

Inability to sleep or sleeping longer?	_____	_____
Increased or decreased appetite?	_____	_____
Tearfulness or feelings of despair?	_____	_____
Lack of energy or feelings of fatigue?	_____	_____
Preoccupation with life events?	_____	_____
Decreased contact with others?	_____	_____
Feelings of depression?	_____	_____
Decreased interest in pleasurable activities	_____	_____

Is there **anything else** that may be **helpful for your counselor to know** that we have not asked?

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Child Checklist of Characteristics

Please check all that apply.

Accident prone
Affectionate
Aggressive
Argues, "talks back," smart-alecky, defiant
Assaults
Bathroom language
Bigoted
Bossy to others
Breaks rules
Breaks the law
Bullied by others
Bullies/ intimidates, teases, inflicts pain on others
Cheats
Clowns around
Competition
Complains
Complains of feeling sick
Compliant
Concern for others
Conflicts at school
Conflicts at home with parents over rule breaking, money, chores, choices
Conflicts with friends
Conflicts with police
Cries easily, feelings are easily hurt
Cruel to animals
Dares others
Dawdles, procrastinates, wastes time
Daydreams
Defiant

Dependent, immature
Destructive
Developmental delays
Difficulties with parent's paramour/new marriage
Disobedient, uncooperative, refuses, noncompliant
Disrupts family activities
Distractible, inattentive, poor concentration, daydreams
Dropping out of school
Drug or alcohol use
Drug sales
Eating issues, poor manners, over/under eats, refuses
Exercise problems
Extracurricular activities interfere with academics
Failure in school
Fantasy life
Fearful
Feelings are easily hurt
Fidgety
Fighting, hitting, violent, aggressive, hostile, threatens
Finger sucking
Fire starting
Fire setting
Friendly, outgoing, social
Hair chewing, pulling
Head banging
Hitting
Hostile
Hyperactive
Hypochondriac, always complains of feeling sick
Imaginary playmates, fantasy

Immature, "clowns around," has only younger playmates
Inappropriate sexual behaviors
Inattentive
Independent
Inflicts pain on others
Insults others
Interrupts, talks out, yells
Intimidated by others
Intimidates others
Intolerant
Irritability
Isolates
Lacks organization, unprepared
Lacks respect for authority, insults, dares, provokes
Learning disability
Legal difficulties, truancy, loitering, vandalism, drinking
Lethargic
Likes to be alone, withdraws, isolates
Loitering
Loss of friends
Low-frustration tolerance, irritability
Lying
Manipulates
Masturbation
Mental retardation
Moody
Mute – refuses to speak
Nail biting
Name calling
Needs high supervision at home over play/chores/schedule
Negativism
Nervous
New school

Nightmares
Noisy
Noncompliant
Obedient
Obesity
Only younger playmates
Oppositional, resists, refuses, does not comply, negativism
Outgoing
Out-of- seat behaviors
Overactive, restless, hyperactive, restlessness, fidgety
Picks on others
Poor concentration
Pouts
Prejudiced, bigoted, insulting, name calling, intolerant
Procrastinates
Provokes others
Rages
Recent move, new school, loss of friends
Refuses
Relationships with friends are poor
Relationships with siblings –

competition, fights, teasing/provoking
Relationships with teachers poor
Resists
Responsible
Restless
Rocking motion/behavior
Repetitive movements
Runs away
Sad, unhappy
School avoiding
Self-harming behaviors—biting, hitting self, scratching
Sexual preoccupation, inappropriate sexual behaviors
Sexually active
Shy, timid
Slow moving
Slow responding
Smart-alecky
Smoking
Social
Speech difficulties
Stealing
Stubborn
Suicide talk or attempt

Swearing, blasphemous, bathroom language, fowl language
Talks back
Teased, picked on, victimized, bullied
Teases others
Temper-tantrums, rages
Threatens
Thumb sucking, finger-sucking
Tics – involuntary rapid movements, noises or word productions
Timid
Truancy, school avoiding
Uncooperative
Uncoordinated, accident-prone
Under-active, slow-moving
Unhappy
Unprepared
Vandalism
Violent
Wastes time
Wetting/soiling of bed or clothes
Withdraws
Yells

Other:

Thank you for completing this questionnaire.