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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:** _____

Current Reason For Seeking Therapy:

- Parent(s) are concerned about me and encouraged me to come
- I asked my parent(s) to see someone I can talk to
- Parent(s) are forcing me to come

What are the reasons for your visit today?

List three issues/conditions that concern you most:

- _____
- _____
- _____

When did you first notice these issues/conditions?

What have you 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 your life that are affecting you right now:

- _____
- _____
- _____

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

Therapy History:

Have you previously seen a therapist? yes no

If yes, what did you find **most helpful** in therapy?

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

Family History:

Are both of your parents living? yes no

Are your parents: married divorced remarried

If you have two parents, how do they get along?

Do you get along with your parents? yes no Why or why not?

Do you have any: siblings step-siblings

Do you get along with them? yes no Why or why not?

If your parents are divorced, what is your living situation like for you?

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

Please check any concerns that your family is currently experiencing:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> fighting | <input type="checkbox"/> feeling distant | <input type="checkbox"/> loss of fun | <input type="checkbox"/> lack of honesty |
| <input type="checkbox"/> physical fights | <input type="checkbox"/> financial problems | <input type="checkbox"/> death of a family member | <input type="checkbox"/> abuse/neglect |
| <input type="checkbox"/> housing problems | <input type="checkbox"/> job change/loss | <input type="checkbox"/> alcohol use | <input type="checkbox"/> drug use |
| <input type="checkbox"/> parent having affair | <input type="checkbox"/> divorce/separation | <input type="checkbox"/> issues with remarriage | <input type="checkbox"/> new sibling |
| <input type="checkbox"/> health issues | <input type="checkbox"/> other _____ | <input type="checkbox"/> other _____ | <input type="checkbox"/> other _____ |

Social History:

List some of the good qualities you like about yourself:

Do you make friends easily? yes no

I consider myself socially (check all that apply): outgoing shy leader follower loner
 socially popular comfortable with my social group an outcast picked on/ teased

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

Do you have a best friend? yes no

Are you happy with the amount of friends you have? yes no

Are your parents happy with your friends? yes no

To what extent can you rely on your friends for support? _____

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

If so, what? _____

What do you like to do in your free time?

Are you dating? yes no Are you currently in a relationship? yes no

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

Do you consider yourself: heterosexual gay lesbian bisexual transgender questioning

Are your parents aware of your sexual preference? yes no

Are you working? yes no What do you do? _____

How many hours a week? _____ Do you enjoy your job? yes no

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

Social Media and Technology:

Check all social media sites you currently use: Snapchat Instagram Facebook Twitter Kik Tumblr Vine
 Youtube other _____ other _____

Do you use email? yes no Do you have a: cell phone ipad/tablet computer gaming system(s) If so,
list: _____

Approximately how many hours per day do you spend on: social media _____ gaming _____ cell phone _____
computer/ipad _____

How much time per day do you watch tv/movies? _____

Do your parents monitor your: cell phone texting ipad/tablet computer gaming system(s)

School History:

Current grade _____ School (name) _____ public private other

Do you like school? yes no Do you attend school regularly? yes no

What are your current grades: _____

Last grade completed: _____ High School Diploma GED Vocational Training College _____

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

Do you currently or have you had an: IEP 504 GATE Program

Lifestyle Behaviors:

Do you have any current physical concerns or chronic health conditions? yes no

Please describe: _____

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

Do you take your prescribed medications daily? yes no

Do you suspect you may misuse any prescription medication? yes no

How would you describe your current physical health? very healthy mostly healthy moderately healthy

often sick almost always sick

How well do you sleep: very well pretty well ok poorly

I sleep: too much not enough have trouble falling asleep have trouble staying asleep

How often do you exercise: daily couple times a week occasionally rarely

What do you do for exercise? _____

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

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

How do you feel about your body?

Individual Concerns:

Please check any you 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:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> anxiety/nervousness | <input type="checkbox"/> explosive temper | <input type="checkbox"/> sadness | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> shyness | <input type="checkbox"/> low energy | <input type="checkbox"/> difficulties concentrating | <input type="checkbox"/> frequent stomachaches |
| <input type="checkbox"/> social problems | <input type="checkbox"/> high energy | <input type="checkbox"/> loneliness | <input type="checkbox"/> frequent illness |
| <input type="checkbox"/> stress | <input type="checkbox"/> unhappy most of the time | <input type="checkbox"/> low self confidence | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> anger | <input type="checkbox"/> cry too often | <input type="checkbox"/> low self esteem | |
| <input type="checkbox"/> fear making mistakes | <input type="checkbox"/> body image | <input type="checkbox"/> obsessive thoughts | |
| | <input type="checkbox"/> death of a pet | <input type="checkbox"/> unusual thoughts | |

Drug/Alcohol History:

Do you currently use alcohol? yes no

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

If so, how much and what do you typically drink?

Do you currently smoke marijuana? yes no

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

Have you ever smoked cigarettes? yes no Do you currently smoke? yes no

If so, how much per day? _____

Have you ever/do you engage in any of the following: Vape Chew Tobacco Electronic Cigarettes

Other _____

Where and when do you typically use? _____

What does using do for you? _____

Does your personality change when you drink? yes no How? _____

Have you ever felt you have needed to cut down on alcohol/pot/substance use? yes no

Have you ever felt annoyed by criticism from others about your alcohol/pot/substance abuse? yes no

Have you ever felt guilty about your alcohol/pot/substance abuse? yes no

Have you ever used alcohol/pot or another substance to get the day started? yes no

Who in your family (not or in the past) has had a problem with drugs or alcohol? _____

Other:

Is there anything else that is important for me to now about you that has not yet been asked or expressed? If yes, please explain here: _____
