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**Teen/Young Adult History Questionnaire (completed by teen/young adult)**

*Please complete the following questionnaire to give me a general understanding of the various aspects of your life. This information will be very helpful in understanding more about you and how best we can work together in therapy.*

**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** yes/no **mobile** yes/no **work** yes/no

**Emergency Contact's name:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_ - \_\_\_\_\_

**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?

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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?

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**Therapy History:**

Have you previously seen a therapist? yes no

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

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

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**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?

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

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Do you have any: siblings step-siblings

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

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

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

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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:

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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?

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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? \_\_\_\_\_

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

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

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What do you like to do in your free time?

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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.

<b>SYMPTOM</b>	NONE	MILD	MOD	SEVERE	<b>SYMPTOM</b>	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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_