# ADOLESCENT INTAKE QUESTIONNAIRE

*Please fill in the information below and bring it with you to your first session.*

***INFORMATION PROVIDED ON THIS FORM IS PROTECTED AS CONFIDENTIAL INFORMATION***

**DATE:**_____

**CLIENT NAME:**_____ **PREFERRED NAME**_____
**CLIENT DATE OF BIRTH**_____ **AGE**_____ **GENDER**_____
**STREET ADDRESS**_____
**CITY, STATE, ZIP** _____
**CLIENT PHONE** (if different from parent/guardian below) _____
Is it OK to leave a message**?** YES NO Is it OK send text message**?** YES NO
**SCHOOL ATTENDING** _____ **GRADE**_____
**IF APPLICABLE, PART-TIME OR SUMMER EMPLOYMENT**_____

**PARENT/LEGAL GUARDIAN #1**_____
**STREET ADDRESS**_____
**CITY, STATE, ZIP** _____
**PHONE** _____ Is it OK to leave a message**?** YES NO Is it OK to send text message**?** YES NO
**E-MAIL** _____ Is it OK to send a message**?** YES NO
*E-mail is not used to communicate protected health information, as e-mail is not considered to be a confidential form of communication*
**PARENT/LEGAL GUARDIAN #2**_____
**STREET ADDRESS**_____
**CITY, STATE, ZIP** _____
**PHONE** _____ Is it OK to leave a message**?** YES NO Is it OK to send text message**?** YES NO

**HOW DID YOU HEAR OF DAWN?** Insurance Website Psychology Today Dr. Paturi ISU Student Health
IWU Student Health Primary Care Provider_____ Friend/Family_____ OTHER_____

## TREATMENT HISTORY

1) Has the client ever received any type of outpatient mental health services (psychotherapy, psychiatric services, etc.)? YES NO
Previous therapist/practitioner_____ Dates_____
Previous therapist/practitioner_____ Dates_____

2) Is the client currently taking any prescription medication for mood/anxiety/focus management? YES NO
If yes, please list
Medication_____ Dosage_____ Managing Practitioner _____
Medication_____ Dosage_____ Managing Practitioner _____

3) Has the client ever been prescribed medication for mood/anxiety/focus management? YES NO
If yes, please list
Medication_____ Reason_____ When_____
Medication_____ Reason_____ When_____

4) Has the client ever been hospitalized or received inpatient treatment for mental health or substance abuse? YES NO
If yes, please list
Reason_____ Dates (approx.)_____ Location_____
Reason_____ Dates (approx.)_____ Location_____

5) What led to counseling being sought at this time? _____
_____

6) What issues would you like to see the client address in counseling? _____
_____
_____

## FAMILY AND SOCIAL HISTORY

7) Who lives in the client's home (circle all relationships to client that apply):

mother father step-parent sibling(s) #____ step-sibling(s) #____ half-sibling(s) #____ aunt uncle

grandmother grandfather niece(s)/nephew(s)#____ other_____

8) Are both parents still living? YES NO If no, please specify how old client was when parent(s) died and manner of death.

_____

9) Do parents live in separate households and share custody of client? YES NO If yes, what are the client's living arrangements?

_____

_____

10) Does the client live with someone other than parents? YES NO If yes, who and how did this come to be?

_____

_____

11) Have any of the following events occurred in your family in the last two years? (check all that apply):

❒Moved to a new place
❒Divorce or separation
❒Change of school
❒Brother or sister leaving home
❒Serious illness or injury to family
❒Marriage of sibling
❒Death in family
❒Difficulties/problems with law
❒Change in financial status
❒Emotional difficulties/problems
❒New baby/child in family
❒Parent remarried
❒Brother or sister moving home
❒Other family/friend moved in
❒Other (specify) _____
_____

| 12) To the best of your knowledge, has anyone in the client's immediate family ever experienced the following mental health/developmental issues whether they were diagnosed or suspected? | | Relationship to client |
|---|---|---|
| Anger/Impulse Control Problems | YES NO | |
| Major Depression | YES NO | |
| Anxiety | YES NO | |
| Obsessive Compulsive Disorder | YES NO | |
| Bipolar Disorder | YES NO | |
| Pervasive Developmental Disorders (e.g. Autism, Asperger's) | YES NO | |
| Eating Disorder (anorexia, bulimia) | YES NO | |
| Alcohol/Substance Abuse | YES NO | |
| Schizophrenia/Psychosis | YES NO | |
| Has anyone close to the client attempted suicide? | YES NO | |
| Has anyone close to the client committed suicide? | YES NO | |

13) Does the client participate in any church, sports, music, drama, or community organization? YES NO If yes, please specify

_____

_____

14) In general, do you feel the client has a positive group of friends? YES NO

## CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

To be completed by parent/guardian

1) What was your child's birth weight? _____lbs. _____oz. Unknown

2) Was delivery normal? ❒Yes ❒Unknown ❒No, specify_____

3) Did the birth mother experience physical or emotional problems during pregnancy? ❒Yes, specify_____
❒No ❒Unknown

4) Were medications taken during pregnancy? ❒Yes, specify_____ ❒No ❒Unknown

5) Did the birth mother use alcohol or street drugs during pregnancy? ❒Yes, specify_____
❒No ❒Unknown

6) Did the baby experience problems immediately after birth? ❒Yes, specify_____ ❒No ❒Unknown

7) Has your child ever had any major illnesses, injuries, medical treatments, or surgeries? ❒Yes, specify_____
_____❒No ❒Unknown

8) Is there a history of physical, sexual, or emotional abuse? ❒Yes, specify _____
_____ ❒No ❒Unknown

9) Is there a history of prolonged separations or traumatic events? ❒Yes, specify_____
_____ ❒No ❒Unknown

10) At what age did your child do the following? *Italicized areas reflect normal development range*.
_____ held head up *(3 to 4 months)*
_____ smiled *(6 months)*
_____ rolled over *(6 months)*
_____ sat alone *(6 to 10 months)*
_____ pulled up *(6 to 10 months)*
_____ crawled *(6 to 10 months)*
_____ walked alone *(12 months)*
_____ talked in single words *(18 to 24 months)*
_____ fed self *(2 years)*
_____ talked in sentences *(30 to 36 months)*
_____ established toilet training *(2½ to 4 years)*
_____ rode a bike *(6 years)*

11) How would you describe your child's approach to new situations?
- ❒ Positive, jumps right in
- ❒ Withdrawn, tends not to participate
- ❒ Slow to warm up, cautious

12) How would you generally describe your child's overall mood?
- ❒ Positive (happy, laughing, upbeat, hopeful)
- ❒ Negative (depressed, cranky, angry, hostile)
- ❒ Mixed but more positive than negative
- ❒ Mixed but more negative than positive

13) Is your child currently receiving special services in school? ❒Yes, specify_____ ❒No

14) Has your child ever failed a class or been held back for academic reasons? ❒Yes, specify grade _____ ❒No

15) Is your child expected to pass this school year? ❒Yes ❒No ❒Unsure

## PROBLEM AND FUNCTIONING SCALES

To be completed by parent/guardian

Form completed by (relationship to client)_____

| | **INSTRUCTIONS:** Regarding your child, please rate how often the following problems have been a concern for you in the past 30 days. | NEVER | RARELY | SOMETIMES | QUITE FREQUENTLY | EVERYDAY |
|---|---|---|---|---|---|---|
| **1** | Arguing with others | 0 | 1 | 2 | 3 | 4 |
| **2** | Getting into physical fights | 0 | 1 | 2 | 3 | 4 |
| **3** | Yelling, swearing, or screaming at others | 0 | 1 | 2 | 3 | 4 |
| **4** | Fits of anger (throwing, slamming, destroying property) | 0 | 1 | 2 | 3 | 4 |
| **5** | Refusing to do things that parents ask | 0 | 1 | 2 | 3 | 4 |
| **6** | Refusing to do things teachers or other adults ask | 0 | 1 | 2 | 3 | 4 |
| **7** | Using drugs or alcohol | 0 | 1 | 2 | 3 | 4 |
| **8** | Breaking rules or breaking the law | 0 | 1 | 2 | 3 | 4 |
| **9** | Missing school or classes | 0 | 1 | 2 | 3 | 4 |
| **10** | Lying or being extremely secretive | 0 | 1 | 2 | 3 | 4 |
| **11** | Can't seem to sit still, having too much energy | 0 | 1 | 2 | 3 | 4 |
| **12** | Hurting self (cutting, burning, hitting/banging head) | 0 | 1 | 2 | 3 | 4 |
| **13** | Thinking about death or dying | 0 | 1 | 2 | 3 | 4 |
| **14** | Feeling worthless or useless | 0 | 1 | 2 | 3 | 4 |
| **15** | Feeling lonely or having no friends | 0 | 1 | 2 | 3 | 4 |
| **16** | Feeling anxious or fearful | 0 | 1 | 2 | 3 | 4 |
| **17** | Worrying that something bad is going to happen | 0 | 1 | 2 | 3 | 4 |
| **18** | Feeling sad or depressed | 0 | 1 | 2 | 3 | 4 |
| **19** | Nightmares | 0 | 1 | 2 | 3 | 4 |
| **20** | Eating problems or change in eating patterns | 0 | 1 | 2 | 3 | 4 |
| **21** | Problems sleeping or change in sleeping patterns | 0 | 1 | 2 | 3 | 4 |
| **22** | Isolating self in room | 0 | 1 | 2 | 3 | 4 |
| **23** | Too much time spent on screen devices (video games, phone, tablet, TV) | 0 | 1 | 2 | 3 | 4 |

Please share any additional comments you may have about the above areas:

_____

_____

_____

_____

_____

_____

## PROBLEM AND FUNCTIONING SCALES (continued)

To be completed by parent/guardian

| | **INSTRUCTIONS:** Read each item and circle the number that best describes your child's current level of functioning. | **POOR** | **FAIR** | **GOOD** | **EXCELLENT** | |
|---|---|---|---|---|---|---|
| **1** | Getting along with friends | 1 | 2 | 3 | 4 | |
| **2** | Getting along with other kids at school/in neighborhood | 1 | 2 | 3 | 4 | |
| **3** | Getting along with mother | 1 | 2 | 3 | 4 | N/A |
| **4** | Getting along with step-mother/mother-figure | 1 | 2 | 3 | 4 | N/A |
| **5** | Getting along with father | 1 | 2 | 3 | 4 | N/A |
| **6** | Getting along with step-father/father-figure | 1 | 2 | 3 | 4 | N/A |
| **7** | Getting along with brothers/sisters | 1 | 2 | 3 | 4 | N/A |
| **8** | Getting along with adults outside the family (teachers, coach) | 1 | 2 | 3 | 4 | |
| **9** | Keeping neat and looking good (caring for age appropriate health and hygiene needs) | 1 | 2 | 3 | 4 | |
| **10** | Controlling emotions | 1 | 2 | 3 | 4 | |
| **11** | Being motivated and finishing projects | 1 | 2 | 3 | 4 | |
| **12** | Participating in hobbies/recreational activities | 1 | 2 | 3 | 4 | |
| **13** | Completing household chores | 1 | 2 | 3 | 4 | |
| **14** | Attending school and getting passing grades | 1 | 2 | 3 | 4 | |
| **15** | Thinking clearly and making good decisions | 1 | 2 | 3 | 4 | |
| **16** | Concentrating, paying attention, and completing tasks | 1 | 2 | 3 | 4 | |
| **17** | Accepting responsibility for actions | 1 | 2 | 3 | 4 | |
| **18** | Expressing feelings | 1 | 2 | 3 | 4 | |
| **19** | Doing things without supervision (age appropriate) | 1 | 2 | 3 | 4 | |
| **20** | Developing healthy relationships with boyfriends/girlfriends (age appropriate) | 1 | 2 | 3 | 4 | |

Please share any additional comments you may have about the above areas:

_____

_____

_____

_____

_____

_____

## HOW ARE YOU DOING?

To be completed by the client

| | **INSTRUCTIONS:** Please circle the number that you think best describes your situation. | NOT AT ALL | A FEW TIMES IN THE PAST *3 MONTHS* | A FEW TIMES IN THE PAST *MONTH* | A FEW TIMES IN THE PAST *WEEK* | EVERYDAY |
|---|---|---|---|---|---|---|
| | **In general, how much do you struggle with:** | | | | | |
| **1** | …getting into trouble? | 0 | 1 | 2 | 3 | 4 |
| **2** | …getting along with your mother/mother figure? N/A | 0 | 1 | 2 | 3 | 4 |
| **3** | …getting along with your father/father figure? N/A | 0 | 1 | 2 | 3 | 4 |
| **4** | …feeling unhappy or sad? | 0 | 1 | 2 | 3 | 4 |
| **5** | …your behavior at school? | 0 | 1 | 2 | 3 | 4 |
| **6** | …having fun? | 0 | 1 | 2 | 3 | 4 |
| **7** | ...getting along with adults other than (your mother and/or your father)? | 0 | 1 | 2 | 3 | 4 |
| **8** | …feeling nervous or afraid? | 0 | 1 | 2 | 3 | 4 |
| **9** | …getting along with your sister(s) and/or brother(s)? N/A | 0 | 1 | 2 | 3 | 4 |
| **10** | …getting along with other kids your age? | 0 | 1 | 2 | 3 | 4 |
| **11** | …getting involved in activities like sports or hobbies? | 0 | 1 | 2 | 3 | 4 |
| **12** | ...your school work? | 0 | 1 | 2 | 3 | 4 |
| **13** | …your behavior at home? | 0 | 1 | 2 | 3 | 4 |
| **14** | …making friends? | 0 | 1 | 2 | 3 | 4 |
| **15** | …thinking about hurting yourself? | 0 | 1 | 2 | 3 | 4 |
| **16** | …thinking about wanting to die? | 0 | 1 | 2 | 3 | 4 |
| **17** | …doing too much of one thing (playing video games, being on phone/tablet, being in bedroom, etc.)? | 0 | 1 | 2 | 3 | 4 |
| **18** | …feeling confused about your sexuality? | 0 | 1 | 2 | 3 | 4 |
| **19** | …feeling comfortable with your gender? | 0 | 1 | 2 | 3 | 4 |
| **20** | …identifying your strengths and talents? | 0 | 1 | 2 | 3 | 4 |

Three things I would like to change in my life are:

1) _____

2) _____

3) _____

Three strengths and talents I have are:

1) _____

2) _____

3) _____