Susan Dellutri, LLC

Adolescent Health and History Questionnaire (ages 12-17)

To be filled out by Adolescent

CLIENT INFORMATION

Name_____ Date of Birth_____Today's Date _____
Phone (cell)_____ Messages okay?_____Text Reminder okay?_____
School_____Grade_____
Please share what electronic communication platforms you use?_____
Do your parents have access? (Y/N) _____ Do they have any issues with your use? (Y/N)_____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?_____
_____
Who or what are some of the influential and supportive people, activities, or beliefs in your life?
Please describe:_____
_____

REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for?_____
_____
What would you like to see happen as a result of counseling?_____
_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? (Y/N) _____ If yes, what did you find **most helpful** in therapy?
_____
If yes, what did you find **least helpful**?_____
_____
Have you seen a psychiatrist or other doctor for medication? (Y/N) _____ Did it help? (Y/N)_____
Do you have a primary care doctor? (Y/N) _____ Doctor's name _____
Do you have allergies? (Y/N) _____ If so, please describe:_____
Are you having any sleep problems? (Y/N)_____ If so, please describe:_____
Are you experiencing any current medical problems? (Y/N) _____ If so, please describe:_____
_____

FAMILY HISTORY

1. Are your parents married or divorced?_____
2. Do you think their relationship **is** good? (Y/N/Unsure)_____
3. If your parents are divorced, whom do you primarily live with?_____
4. How often do you see each parent? Mom_____%. Dad_____%
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable_____

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Legal issues
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Trauma
	Medical concerns		Other

SCHOOL HISTORY

1. Do you like school? _____
2. Do you attend regularly? _____
3. What are your current grades?_____
4. Do you feel you are doing the best you can at school?_____
5. Have you ever been in special classes or programs for academic, behavioral, or emotional help? (Y/N)____

PEER RELATIONS

1. How do you consider yourself socially? ___Outgoing ___Shy ___Depends on the situation
2. Are you happy with the amount of friends you have? (Y/N) _____
3. Have you ever been bullied? (Y/N)_____
4. Are your parents happy with your friends? (Y/N)_____
5. Are you involved in any organized activities? (Y/N) ____ Please describe:_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol?_____Yes _____No
If yes, how often do you drink?_____Daily _____ Weekly _____Occasionally _____Rarely
If yes, how much do you drink? _____Number per time
Do you currently use tobacco?_____Yes _____No
If yes, how much do you smoke/chew?_____
Do you currently use any other drugs?_____Yes _____No
If yes, what drugs do you use?_____
If yes, how often do you use?____Daily _____Weekly _____Occasionally _____Rarely

Have you received any previous treatment for chemical use?_____Yes _____No
If yes, where did you go? _____

INDIVIDUAL CONCERNS*

SYMPTOM	NONE	MILD	MOD	BAD		SYMPTOM	NONE	MILD	MOD	BAD
Sadness						Appetite change				
Crying						Social Isolation				
Trouble Sleeping						Paranoid Thoughts				
Weight Changes Unplanned						Poor Concentrartion				
Problems at home						Indecisiveness				
Hyperactivity						Low Energy				
Binging/Purging						Excessive Worry				
Loneliness						Low Self Worth				
Unresolved Guilt						Anger Issues				
Irritability						Spiritual Concerns				
Nausea/IBS						Hallucinations				
Social Anxiety						Racing Thoughts				
Self Mutalation						Restlessness				
Cutting						Drug Use				
Impulsivity						Alcohol Use				
Nightmares						Easily Distracted				
Hopelessness						Trauma Flashback				
Elevated Mood						Panic Attacks				
Obsessive Thoughts						Past Suicide Attempts				
Mood Swings						Feeling Anxious				
Disorganized						Feeling Panicky				
Anorexia						Suicidal Thoughts				
Grief						Phobias				
Headaches						Other				

*Your individual privacy is respected and protected by law. We will cover the privacy law in the first session with both you and your parents.

Signature_____ Date_____