Adolescent Questionnaire

Name:_____ **Date:**_____

This questionnaire is designed to help me get to know you. Please answer each of the following questions to the best of your ability – if you do not feel comfortable answering a question, please leave it blank. Feel free to use the back of each page if more room is needed to answer a particular question than the space provided. There are quite a few questions and I appreciate your time and effort to complete this questionnaire so that I can begin to get to know you! *I also look forward to getting to know you in person as well.*

Note: *Please remember that the information you share with me is confidential (private) unless I feel you're a risk of harm to yourself, someone else or someone is hurting you. In those cases, I will take the necessary steps to keep you and/or others safe.*

1. Briefly describe what brings you to therapy now.

2. How long have these issues been happening?

3. How are the above issues affecting you?

4. Are they affecting the relationships with your family? (if yes, describe)

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5. Are the problems affecting your friendships? (if yes, please describe)

6. Are the problems affecting how you're doing in school? (if yes, describe)

7. Do you want therapy? If yes, why (what do you hope to get out of it?). If no, why not.

8. Have you been in therapy before? If yes, what was helpful and/or not helpful about it?

About You:

1. How would you describe yourself?

2. What do you like/dislike about yourself?

3. What do other people like/dislike about you?

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4. What do you like to do for fun?

5. Do you like school? Explain.

6. Have you ever experienced feeling very sad or depressed? (if yes, describe)

7. Have you ever experienced feeing very anxious or worried? (if yes, describe)

8. Have you ever experienced feeling very angry? (if yes, describe)

9. Have you ever felt like harming yourself – if yes, have you ever acted on those feelings? If yes, how so and when?

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10. Have you ever felt like harming anyone else? If yes, have you ever acted on those feelings? If yes, how so and when was the last time you did?

11. Has anyone ever harmed you? If yes, how so?

12. Do you have difficulty sleeping? (if yes, describe)

13. Do you have difficulty eating? (if yes, describe)

14. Do you have any medical problems? (if yes, describe)

15. Are you currently taking any medications? If yes, what ones and what for? Are they helpful to you?

16. Are you using cigarettes, drugs and/or alcohol? (if yes, describe)

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17. Are you happy with your friendships? Please describe.

18. Are you sexually active? (now or in the past) If yes, at what age did you become sexually active?

19. Do you identify with a particular sexual orientation? If yes, which one?

20. What is your gender? _____ Do you identify under the trans umbrella? ❑· yes ❑ no

21. Do you use social media? If yes, what apps?

22. If you use social media, have you ever had any problems wit it? Does it cause any difficulties for you and your relationships? Please describe.

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About Your Family

1. How did you join your family? Please circle what applies:

Natural Birth *Birth through use of Reproductive Technology* *Foster Care/Adoption*

2. Describe your family.

3. How would your family describe you?

4. Who are you closest to in your family?

5. Who in your family are you the *least* closest to? Do you wish you could be closer to that person?

6. What are some good things about your family?

7. Are there things you wish you could change about your family? If yes, what would you change?

Last Questions! ☺

1. How can a therapist be most helpful to you?

2. Is there anything else important for me to know about you or that you want to share with me at this time?

Thank you for completing this assessment form!