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Confidential Adolescent Questionnaire
(To be Completed by Adolescent Client)

Your Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (Zip)

Home Phone: _____ Cell: _____ OK to leave message? _____

Email: _____ Best way to contact you? _____

School Attending: _____ Grade Level: _____

Name of Employer (if applicable): _____ Hours/Week: _____

Please answer the following questions to the best of your ability:

What are the main reasons that you are seeking assistance?

_____

_____

_____

Have you ever been evaluated for developmental, behavioral or learning problems? _____ If so, can you explain why you were evaluated and by whom? What was shared with you regarding the results?

_____

_____

Have you ever received psychiatric or psychological treatment? _____ If yes, please explain why, what type, with whom, and how long the treatment lasted:

_____

_____

Did you feel that the treatment was helpful? Why or why not?

_____

_____

Have you ever been prescribed medications for emotional or behavioral issues? _____ If so, please describe what medication was prescribed, amount of dosage, for how long, how effective it has been, and whether or not you are still taking this medication:

_____

_____

Do any of the following issues or behaviors apply to you?

Suicidal thoughts: _____ Suicide attempts: _____ Domestic Violence: _____ Substance Abuse*: _____

Eating Disorders**: _____ Other: _____

_____

*If you use substances, which of the following do you use?

Alcohol ____ Tobacco ____ Marijuana ____ Cocaine ____ Methamphetamines ____

Opiates ____ Club Drugs ____ Other _____

_____

**If you have an eating disorder, which of the following applies to you:

Restricting ____ Binging ____ Purging ____ Other _____

_____

What is your desired outcome from seeking treatment with Ms. Grellman?

_____

_____

Is there anything else Ms. Grellman should know in order to assist you?

_____

_____

_____