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# TEEN AND YOUNG ADULT CLINICAL INTAKE QUESTIONNAIRE

Please answer all of the questions on the following pages as honestly and accurately as you can. Your answers to these questions are private and no one will see them but your counselor (not even parents unless you give permission). The information you provide gives us a head-start in understanding how we can be of help.

What is your?

Name ______________________________ Date of birth ____________

Age __________ Gender ____________ Grade ________________

School ________________________________________________

Are you involved in after school activities (sports, karate, dance, etc.)? __________

If yes, what are your activities? ______________________________

Do you have a job? ______ If yes, where do you work? ______________

Parents' (or guardians') names ______________________________

Briefly describe your everyday life (like where you live, who you live with, if you have any pets, who are the important people in your life, what it's like living in your home, and anything else you want share).

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Name all people living in your house, their ages, and their relationships to you:

| Name | Age | Relationship |
|---|---|---|
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Whose idea was it for you to come to counseling?

_______________________________________________

What is the reason for your counseling appointment?

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

If it was someone else's idea for you to come for counseling, why do you think they wanted you to come?

_______________________________________________
_______________________________________________
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If you are having bad feelings or thoughts, please describe them in your own words.

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_______________________________________________
_______________________________________________
_______________________________________________

What are you most worried might happen if things don't change?

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Have you ever had similar thoughts, feelings, or problems before now? If yes, please describe them, when they occurred, and if anything was done about them.

_______________________________________________
_______________________________________________
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_______________________________________________

Have you ever seen another professional (counselor, therapist, psychologist, or psychiatrist) for emotional, behavioral, or learning problems?

______________________________________________________________________

If yes, do you think it helped?

______________________________________________________________________

Have you ever taken medication to help with emotional, behavioral, or learning problems?

______________________________________________________________________

If yes, when? ______________________________________________________

If you are taking medication now and you know what it is, please list the medicines you take. If you don't know, you can skip this part.

Name of medication

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Do you have any medical or physical problems that are currently bothering you or for which you see a doctor. If so, describe them in your own words.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

HISTORY OF IMPORTANT LIFE EVENTS AND PROBLEMS**:**

Please place a check in front of all the statements below that apply to you:

☐ I had to repeat a grade in school

☐ I have been in at least one special education class

☐ I have been in advanced classes for smart kids

☐ I have been in gifted or AP classes?

Do any of the following statements describe you (check all that fit):

☐ I often leave things unfinished

☐ I am easily distracted or have trouble paying attention

☐ I have difficulty concentrating on reading or homework

☐ I have difficulty sitting still

☐ I feel restless, fidgety, like I need to move

☐ I sometimes act without thinking about what I'm doing or what the consequences might be

☐ I often misplace or lose things

☐ I forget things easily and need to be reminded a lot

Check the statements below that best describe you and the things you've done (check all that apply):

☐ I am unusually stubborn and want things my way

☐ I have trouble following rules

☐ I often do the opposite of what people tell me to do

☐ I argue with my parents and teachers

☐ I tend to lose my temper easily, and sometimes throw or break things

☐ I have shoplifted or stolen something

☐ I have skipped school without permission

☐ I have run away from home overnight

☐ I often tell lies to my parents or teachers

☐ I have snuck out of the house at night

☐ I have set fires that could have been dangerous

☐ I have injured or killed a pet or small animal just for fun

☐ I have purposely broken or damaged someone else's property

☐ I have a reputation for starting fights

☐ I have pulled a knife or gun on someone

☐ I have tried to steal things by threatening someone

☐ I have tried to force another person to engage in a sexual act

Check the ones below that apply to you:

☐ I smoke cigarettes regularly

☐ I have drunk beer, wine, or other alcoholic beverages, recently or in the past

☐ I have missed school or my job (or was asked to leave) because of drinking

☐ I have sniffed glue, gasoline, or fumes to get high

☐ I have smoked weed (marijuana)

☐ I have used amphetamines (crystal meth, Molly, ice, speed)

☐ I have used cocaine (coke, crack, rocks)

☐ I have used hallucinogens (LSD, PCP, peyote, mescaline)?

☐ I have used heroin, opiates (junk, mud, horse)?

☐ I have abused prescription medication (roxys, blues, pain/sleep, ADD meds)

☐ I have abused other medicines like DXM

☐ I have abused sedatives, tranquilizers (downers, bars, Xanax)?

☐ I am regularly using some of the above substances now

Have you recently or in the past had a period of time that lasted two weeks or longer when you:

☐ seemed to be sad, depressed, in a bad mood?

☐ felt like you could cry or get upset more easily than usual?

☐ felt more irritable or got angry more easily?

☐ didn't feel much like eating or lost weight?

☐ felt like eating more than usual or gained extra weight?

☐ had trouble falling asleep or staying asleep?

☐ slept more than usual or had trouble waking up?

☐ didn't feel like being around family and friends; talked less than usual?

☐ lost interest in things you usually like to do?

☐ had less energy or motivation than you usually do?

☐ felt tired a lot of the time but weren't physically sick?

☐ felt achy a lot of the time (headaches, stomachaches, etc.)?

☐ felt guilty over things you really weren't to blame for?

☐ felt worthless and thought you would be better off dead?

☐ couldn't concentrate as well on school or work?

☐ talked about you or some one else dying?

☐ thought a lot about death or dying?

☐ I am feeling sad, blue, moody, or irritable now (check if yes).

☐ I have experienced at least five of the items checked in this section continuously for the past two weeks or longer (check if yes).

Have you ever had a period of time lasting at least one week when you:

☐ were so overly happy or "high" (not on drugs) that you got into trouble?

☐ became more hyper than usual so much so that it made others worry about you?

☐ talked faster or more constantly than usual?

☐ felt your thoughts were going very fast (racing) in your head?

☐ felt you had special powers to do amazing things?

☐ slept a lot less than usual and didn't feel overly tired?

☐ weren't able to concentrate on things as well as usual?

☐ did outrageous, over the top things you later regretted (like acting wild, spending money, taking risks, sex)?

Please check the statements below that describe you most of the time:

☐ I am an anxious (nervous) person

☐ I tend to worry a lot

☐ I sometimes think too much about my health or worry a lot about being sick

☐ I worry about being away from my parents

☐ I feel very uncomfortable (nervous) around people unless I know them well

☐ I sometimes have headaches or stomach aches before school

☐ I worry that something will happen to me or my parents

☐ I need to have a parent close to me to fall asleep

☐ I have had an attack of severe nervousness or anxiety for no apparent reason. If yes, how often have you experienced these attacks?

____________________________________________________________

During an anxiety attack I (check all that apply—skip if you don't have anxiety attacks):

☐ have trouble catching my breath

☐ my heart races too fast

☐ my face becomes red or flushed or my hands begin to sweat

☐ feel afraid but don't know why?

☐ am scared I will faint or lose control?

Please check all of the following that are true about you:

☐ I have had unusual, troublesome (scary) thoughts that I can't put out of my mind (like getting hurt, germs, bugs, etc.)

☐ I have special habits or rituals that I have to do that seem excessive or unnecessary (counting things, touching, hand washing, etc)

☐ I check and recheck way too much on things I've already done, like turning off a light or locking a door

☐ I tend to get highly upset when things are not in their exact place

☐ I think I am too fat

☐ I have lost a lot of weight on purpose

☐ I exercise in order to lose weight

☐ I go on eating binges where I eat way too much at once

☐ I have made myself throw up after regular meals or after binging on food

☐ I have tried diet pills or laxatives to lose weight

☐ I have sudden, jerky movements, which are repetitive, like neck jerks, eye blinking, mouth twitches, shoulder shrugs?

☐ I have a habit (now or in the past) of making repetitive sounds such as sniffs, grunts, throat clearing, barking, etc.

☐ I currently or used to have a habit of rocking my body or moving my fingers and hands in a repetitive way?

Sometimes I have had strange thoughts or experiences that I didn't understand, such as (check the boxes that apply):

☐ thinking someone was out to get me?

☐ thinking that others could control my thoughts?

☐ believing that someone on TV or other media was talking about me

☐ hearing voices in my head that seemed real and were telling me strange things?

☐ seeing things that others couldn't see?

Check the box in front of each statement below that describes you:

☐ I don't seem to like affection such as hugs, kisses, or sitting close to people

☐ I am sort of uninterested in or feel weird around other kids my age

☐ People seem to think I use unusual or peculiar language with others

☐ I still wet the bed or have daytime urinary or bowel accidents

☐ I think I am more interested in things (or video/computer games) than in people

☐ I sometimes have repeated movements that I can't control, like flapping my hands or arms, clapping, twirling, etc.

☐ I get very upset with even small changes in to my routine or when things are out of place

☐ I have habits of hurting myself (cutting, biting, hitting)

If there is anything else you want to tell about yourself or important things happening in your life, you may write anything you want in the space below.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

*Thank you for taking the time to answer these important questions. The information you provided is helpful to your counselor in getting to know you and how to best help you and your family.*