



**CONFIDENTIAL HISTORY QUESTIONNAIRE FOR ADOLESCENTS**  
Completed by the Adolescent

<b>I. GENERAL INFORMATION</b>		
NAME:		
AGE:		
MOTHER'S NAME AND AGE:		FATHER'S NAME AND AGE:
WERE YOU ADOPTED? ___ YES ___ NO IF YES, AT WHAT AGE: ____	ARE YOUR PARENTS DIVORCED? ___ YES ___ NO SEPARATED? ___ YES ___ NO	DO YOU HAVE ANY STEPPARENTS? ___ YES ___ NO
NAMES AND AGES OF BROTHERS AND SISTERS (PLEASE INCLUDE STEP-BROTHERS/SISTERS AND HALF-BROTHERS/SISTERS)		
LIST THE FAMILY MEMBERS THAT LIVE AT HOME WITH YOU:		
HAVE YOU EVER BEEN IN TROUBLE WITH THE POLICE? IF YES, FOR WHAT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
HOW MANY TIMES HAVE YOU BEEN ARRESTED?		
HAVE YOU SPENT ANY TIME IN DETENTION OR JAIL?		
<b>II. HEALTH</b>		
LIST ANY MEDICAL PROBLEMS YOU HAVE HAD, INCLUDING THE TIME FROM BIRTH TO PRESENT		
WHAT MEDICATIONS DO YOU TAKE?		
HAVE YOU EVER HAD MENTAL HEALTH COUNSELING OR PSYCHIATRIC TREATMENT IN THE PAST? IF YES, EXPLAIN. <input type="checkbox"/> YES <input type="checkbox"/> NO		

PLEASE CHECK THE RESPONSE THAT BEST DESCRIBES HOW YOU EXPERIENCE THE FOLLOWING SYMPTOMS.

How often do you have trouble falling asleep or staying asleep all night?

- Almost never       More than once a week  
 About once a week       Almost every day

I am eating:

- A little less than usual       A little more than usual  
 A lot less than usual       A lot more than usual  
 About the same as usual

How well do you enjoy your favorite activities?

- I enjoy them as much as always  
 I enjoy them more than I used to  
 I enjoy them a little less than I used to  
 I enjoy them a lot less than I used to

How often do you think about suicide?

- Almost Never
- Sometimes I think about it but I would never consider doing it.
- I think about it often but I don't think I would go through with it
- I think about it and I know exactly how I would do it.

How energetic do you feel?

- Usually I have a lot of energy
- Sometimes I feel energetic, sometimes I feel tired
- Most of the time I feel tired and it's hard to get myself to do things.
- Sometimes I have more energy than normal and need less sleep than usual, lasting two days or more in a row.

How difficult do you find it to concentrate?

- I can concentrate well on everything
- I can concentrate well only on things that interest me.
- I can concentrate sometimes, but only on things that interest me.
- I can't seem to concentrate on anything very well.

HAVE YOU EVERY ATTEMPTED SUICIDE BEFORE? IF YES, WHEN DID YOU ATTEMPT SUICIDE AND WHAT DID YOU DO.

- YES  NO

Check the amount of each substance you use:

Beer (12oz can), wine, or liquor?

- More than one drink per day.
- More than one drink per week but less than one drink per day.
- Less than one drink per week.
- Almost never.
- Have never tried beer, wine or liquor.

Other Drugs (i.e. speed, cocaine, heroine, etc.)?

- Daily.
- Once or twice a week.
- Less than once a week.
- Have tried other drugs, but I don't use them regularly.
- Have never any other drugs.

Marijuana?

- Daily.
- Once or twice a week.
- Less than once a week.
- Have tried it, but I don't use it regularly.
- Have never tried marijuana.

Check which substances your parents use.

- Alcohol
- Cigarettes
- Marijuana
- Other illicit drugs

Cigarettes?

- More than 20 cigarettes per day.
- 10-20 cigarettes per day.
- Less than 20 cigarettes per week.
- Have tried cigarettes, but don't use them regularly.
- Have never tried cigarettes.

Are you currently having sex?

- YES  NO

Have you ever been sexually abused?

- YES  NO

Do you have any confusion in regard to your sexual identity?

- YES  NO

Do you practice safe sex?

- YES  NO

III. FAMILY
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HOW DO YOU GET ALONG WITH YOUR MOTHER? STEP MOTHER?

HOW DO YOU GET ALONG WITH YOUR FATHER? STEP FATHER?

HOW DO YOU GET ALONG WITH YOUR BROTHERS AND SISTERS? (FULL, STEP AND HALF)  
HOW DO YOUR PARENTS GET ALONG? STEP PARENTS?

WHICH FAMILY MEMBERS ARE YOU CLOSEST TO AND WHY?

HAVE YOU EVER RUN AWAY FROM HOME?  YES  NO  
IF SO, WHEN WAS THIS, WHY DID YOU RUN AWAY AND HOW LONG WERE YOU GONE?

LIST ANY EMOTIONAL OR SUBSTANCE ABUSE PROBLEMS OF RELATIVES.

PROBLEM	RELATIONSHIP TO YOU
_____	_____
_____	_____
_____	_____
_____	_____

IV. SCHOOL

WHAT GRADE ARE YOU IN? (CHECK ONE)

- 7<sup>TH</sup>  8<sup>TH</sup>  Freshman  Sophomore  Junior  Senior  Not in school

WHAT IS YOUR APPROXIMATE GRADE AVERAGE IN SCHOOL? (CHECK ONE)

- A  B  C  D  F

WHAT DO YOU LIKE BEST ABOUT SCHOOL?

WHAT DO YOU LIKE LEAST ABOUT SCHOOL?

HAVE YOU EVER DITCHED SCHOOL?

WHAT ARE YOUR FUTURE PLANS FOR SCHOOL AND CAREER?

CHECK APPROPRIATE DESCRIPTION

- |             |                                       |                                  |                                            |                                    |
|-------------|---------------------------------------|----------------------------------|--------------------------------------------|------------------------------------|
| ATHLETICS:  | <input type="checkbox"/> active       | <input type="checkbox"/> average | <input type="checkbox"/> less than average | <input type="checkbox"/> none      |
| GRADES:     | <input type="checkbox"/> honor roll   | <input type="checkbox"/> average | <input type="checkbox"/> below average     | <input type="checkbox"/> varied    |
| POPULARITY: | <input type="checkbox"/> very popular | <input type="checkbox"/> popular | <input type="checkbox"/> average           | <input type="checkbox"/> unpopular |
| DATING:     | <input type="checkbox"/> much         | <input type="checkbox"/> average | <input type="checkbox"/> little            | <input type="checkbox"/> none      |

V. FRIENDS

DO YOU HAVE A BEST FRIEND? IF SO, HOW LONG HAVE YOU BEEN CLOSE FRIENDS? \_\_\_\_\_  
 YES  NO

HOW MANY OTHER PEOPLE ARE YOU CLOSE FRIENDS WITH? \_\_\_\_\_

WHAT KINDS OF THINGS DO YOU DO WITH YOUR FRIENDS? (CHECK ALL THAT APPLY)

- |                                                                |                                                                                                             |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Go to concerts and/or listen to music | <input type="checkbox"/> Take part in extracurricular activities together (i.e. teams, bands, cheerleading) |
| <input type="checkbox"/> Go to the movies                      | <input type="checkbox"/> Do drugs and drink together                                                        |
| <input type="checkbox"/> Go to the mall                        | <input type="checkbox"/> Talk about anything and everything together                                        |
| <input type="checkbox"/> Eat lunch together at school          | <input type="checkbox"/> Other: _____                                                                       |
| <input type="checkbox"/> Get together on weekend nights        | _____                                                                                                       |
| <input type="checkbox"/> Play sports                           | <input type="checkbox"/> Hang out                                                                           |

DO YOUR PARENTS LIKE YOUR FRIENDS?

- Yes  No  Some of them

VI. TREATMENT

MY MAIN REASONS FOR SEEKING HELP ARE:

MY PROBLEMS WOULD BE IMPROVED IF:

HOW STRONGLY DO YOU WANT HELP FOR YOUR PROBLEMS? (CHECK ONE)

- Very much  Somewhat  Could do without