Rachel Lacy, Psy.D., P.C.
3883 Rogers Bridge Road, St.e 302A
Duluth, GA 30097

# TEEN QUESTIONNAIRE FOR PARENTS

**Confidential**

**Information requested on this questionnaire will aid us in understanding your teenager's problems. We would appreciate you filling it out carefully and fully. Please feel free to add as much information as you want. You may use the backs of pages if necessary.**

**Name**_____ **Date**_____

**Address** _____
**(street) (city/state) (zip)**

**Social Security #** _____**Date of birth**_____

**Home phone #** _____**Business phone #**_____

**Age** _____**Sex** _____**School**_____**Grade**_____

**Referred by** _____**Phone #**_____

***In case of emergency, contact:***_____

**Relationship** _____**Phone #**_____

**Address**_____
**(street) (city/state) (zip)**

**Current living situation**_____

**Driving?** _____**Last time drove?**_____

**Describe the illness(es) or accident(s) that made, or may have made, a big change in your teen's life and give the dates of their occurrence.**

**Accident/ Illness** **Date**

_____

_____

_____

_____

**Was patient unconscious?** _____**How long?**_____
_____

**Was there a period of time for which your teen had no memory?** _____
**How long?** _____

**Describe the patient's physical health.**_____

**Date of last physical exam** _____

**Physician(s):**

| Name | Type of Doctor | Address | Phone |
|---|---|---|---|

**List any prescribed medications the patient is presently taking. Include dosages and dates started.**

| Medication | Dosage | Times Taken Per Day | Date Started |
|---|---|---|---|

**List over-the-counter medications the patient takes fairly often, including vitamins, supplements and herbal remedies.**

**Describe any other serious illness, hospitalizations, accidents or operations:**

| Date | Name of doctor or hospital | Location | Nature of Illness/ Surgery |
|---|---|---|---|

**Please indicate if your teen has had any history of the following:**

**__Alcohol use**
**__Allergies (Type: ____)**
**__Anemia**
**__Anoxia or hypoxia**
**__Cancer**
**__Cancer treatment**
**__Cerebral vascular disease**
**__Cerebral Palsy**
**__Cortisol deficiency**
**__Diabetes or hypoglycemia**
**__Gastrointestinal disorders**
**__Genital or urinary problems**
**__Headaches**
**__Head trauma**
**__Heart Murmur or defect**
**__HIV**
**__Lyme's Disease**
**__Motor Difficulties**
**__Pernicious Anemia**
**__ Premature Birth**
**__Porphyria**
**__Renal disease**
**__Respiratory problems**
**__Seizures**
**__Sleep problems**
**__Substance abuse**
**__Syncope (fainting)**
**__Systemic lupus erythematosus**
**__Toxic (mold) or heavy metal exposure**
**__Vertigo**
**__Vitamin deficiencies**

**Developmental History:**
**Problems and/or maternal use of drugs during pregnancy _____**
**_____**
**Place of birth_____ Birth order_____**
**Birth weight_____ Problems during or after delivery_____**
**_____**
**Developmental milestones: age walking_____ age talking_____ age toileting_____**
**Engaging peers_____ Tolerating separation _____playing cooperatively_____**

**Childhood diseases or history of health problems: _____**
**_____**
**_____**

**Emotional or behavioral problems during childhood and adolescence:_____**
**_____**
**_____**

**History of learning disabilities_____**
**_____**
**_____**

**History of ADD/ ADHD:_____Previous Testing? When? _____**

**History of physical, sexual, or emotional abuse/trauma**
**_____**
**_____**
**_____**

**History of head trauma _____**
**_____**
**_____**

**Please indicate if the following stressors are currently present in your teen's life. Circle all that apply and describe the nature of the problem.**

**Behavioral Problems**_____ **Recent problems with the law**_____
**Medical problems**_____ **School suspensions** _____
**Loss of Friends** _____ **Recent family conflict** _____
**Conflicts with others**_____ **Academic difficulties** _____
**Running away**_____ **Other**_____

**History of previous emotional or psychiatric difficulties:**

_____
_____

**History of suicidal ideation or behavior:**_____
_____

**History of psychiatric treatment:**_____
_____
_____

**History of hospitalizations for emotional problems:**_____
_____

**History of psychiatric medications:**

| Name of Medication | Date Started | Length of Time Taken | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Past alcohol and drug use:**

| Name of Substance | Age started | How Much? | How Often? | Heaviest Use? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Present alcohol and drug use:**

| Name of Substance | Age started | How Much? | How Often? | Heaviest Use? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Do you use tobacco products?**____ **What type?**_____ **How much per day?**_____
**Past use of tobacco: Age started**_____ **Heaviest use?**_____
**For how long?**_____**If stopped, when?**_____

**Caffeine?_____ Coffee, tea, soda, or pills?_____ How much per day?_____**

**List all the people living in your current household. Note any adopted or step-children.**

| Name | Relationship | Age | Education | Occupation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**List parents and siblings. If deceased, note year of death and age at the time.**

| Name | Relationship | Age | Education | Occupation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Parent's marital status_____ If divorced, who has custody?_____**
**Description of parent's relationship_____**
**Physical and emotional health of parents and siblings _____**
_____

**Current support system _____**
**Number of friends and ability to get along with others: _____**
_____

**Circle the physical or neurological problems that run in your family.**

| | | | | |
|---|---|---|---|---|
| **Arthritis** | **Diabetes** | **Huntington's chorea** | **Stroke** | **Cancer** |
| **Epilepsy** | **Heart Disease** | **Bipolar Disorder** | **Depression** | **Schizophrenia** |
| **Alzheimer Disease** | | **Highblood pressure** | **Thyroid Disorders** | |

**Other_____**

**Family alcohol and substance abuse history:**
_____
_____
_____
_____

**Family psychiatric history, illnesses and/or treatment:**
_____
_____
_____
_____

**Family criminal history:**

_____

_____

_____

**Patient's legal history: (If applicable)**
**Arrests_____Type of criminal offense_____**

_____

**Time served in jail_____**
**Time in probation_____**
**Prior history of litiagation_____**
**Current legal problems_____**
**Current court cases_____**

**Education history**

| School | Dates | Location | Degree/ diploma |
|---|---|---|---|

_____

_____

_____

_____

_____

**Highest grade completed: _____**
**Future plans for college or technical school: _____**

**Describe any school related difficulties such as trouble learning to read, write, spell or do arithmetic; repeating a grade, or being placed in special education classes.**

_____

_____

_____

**History of conduct or behavioral problems: (Lying, stealing, running away, cutting behavior, aggression)_____**

_____

**What were your teen's grades like in elementary school (please provide grades obtained)? Were they fairly consistent? If not, what subjects were problematic, or was it a time period that grades decreased?_____**

_____

**What have grades been like in high school? Were they fairly consistent? If not, when did your teen do well and when did they do less well?_____**

_____

**Extracurricular activities in school: _____**

_____

**Awards and achievements:_____**

_____

**Is the patient right-handed ?___ left-handed ?___ or ambidextrous?_____(check one and explain if ambidextrous, what activities does the person use which hand)_____**

**List anyone in your family of origin who was left-handed or ambidextrous.**_____
_____

**Any summer or part time jobs?** _____
_____
**Longest held job:**_____**History of job terminations:**_____
**History of job promotions:**_____

**What were your teen's main hobbies and interests BEFORE the illness or accident?**_____
_____
**What are your teen's main hobbies and interests AFTER the illness or accident?**_____
_____

**Cultural Background: Country of Birth:** _____**First language spoken:**_____
**Other languages spoken:** _____ **Preferred language:** _____
**Ethnic background of patients and family:** _____
**History of Discriminations:** _____
_____
**Religious background:**_____ **Church/ Temple/ Mosque attendance**_____

**In the next section please describe your teen in regard to each of the following aspects of thinking, feeling, or behavior. Describe the situation before the accident or illness on the left and the recent or current on condition on the right.** ***If the condition is one that your teen has had all of his or her life, then only complete the column on the left side of the page, ex: ADHD or learning problems.***

| **Before the accident or illness** | | **Recently and currently** |
|---|---|---|
| | **Concentration** | |
| _____ | | _____ |
| _____ | | _____ |
| | **Energy and activity level** | |
| _____ | | _____ |
| _____ | | _____ |
| | **Depression** | |
| _____ | | _____ |
| _____ | | _____ |
| | **Elation and other types of high mood** | |
| _____ | | _____ |
| _____ | | _____ |
| | **Sleep** | |
| _____ | | _____ |
| _____ | | _____ |
| | **Anger or Anger Control Problems** | |
| _____ | | _____ |
| _____ | | _____ |

| Before the accident or illness | Recently and currently |
| --- | --- |
| **Agitation or Irritability** | |
| | |
| **Running Away or Oppositional Behavior** | |
| | |
| **Appetite for food** | |
| | |
| **Sexual behavior and sexual interest** | |
| | |
| **Consumption of alcohol and other drugs** | |
| | |
| **Hearing** | |
| | |
| **Vision and other aspects of sight** | |
| | |
| **Ability to find way around - Spatial ability** | |
| | |
| **Headaches** | |
| | |
| **Pains other than in the head** | |
| | |
| **Fatigue** | |
| | |
| **Understanding what people say** | |
| | |

| Before the accident or illness | Recently and currently |
|---|---|
| **Ability to finding words when talking** | |
| | |
| **Memory for things people say or things he/she needs to do** | |
| | |
| **Imagery and memory for faces** | |
| | |
| **Reading** | |
| | |
| **Calculating – performing math** | |
| | |
| **School work** | |
| | |
| **Playing or listening to music** | |
| | |
| **Motor behavior - skillful activity** | |
| | |
| **Unusual sensations or strange experiences** | |
| | |
| **Ability to relax and experience pleasure** | |
| | |
| **Social behavior - being with people** | |
| | |

**Please use the back page for additional information which you think would be helpful.**

**Name** _____ **Relationship to client**_____

**Address**_____**Phone**_____