

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:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Lyme's Disease |
| <input type="checkbox"/> Allergies (Type: _____) | <input type="checkbox"/> Motor Difficulties |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Pernicious Anemia |
| <input type="checkbox"/> Anoxia or hypoxia | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Porphyria |
| <input type="checkbox"/> Cancer treatment | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Cerebral vascular disease | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cortisol deficiency | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Diabetes or hypoglycemia | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> Syncope (fainting) |
| <input type="checkbox"/> Genital or urinary problems | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Toxic (mold) or heavy metal exposure |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Heart Murmur or defect | <input type="checkbox"/> Vitamin deficiencies |
| <input type="checkbox"/> HIV | |

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 teen 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 _____