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TEEN QUESTIONNAIRE SELF REPORT

Confidential

Information requested on this questionnaire will aid us in understanding your 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_______________________________

Age___________ Sex___________ School________________________Grade_______

In the next section please describe yourself 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 you have had all of your life, then only complete the column on the left side of the page.***

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

__________________________ __________________________
__________________________ __________________________

Agitation or Irritability

__________________________ __________________________
__________________________ __________________________

Before the accident or illness | **Recently and currently**

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 you hear

Your ability to finding words when you know what you want to say

Before the accident or illness | **Recently and currently**

Your memory for things people say or things you need to do

____________________ ____________________
____________________ ____________________

Imagery and memory for faces

Reading

Calculating - balancing check book

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.
If another person assisted in completing this form, please enter appropriate information below.

Name ________________________________ **Relationship to client**____________________
Address___________________________________**Phone**_________________________________