Clarity Psychological Group, LLC.
ADOLESCENT SELF QUESTIONNAIRE

CLIENT DEMOGRAPHICS

Client **Name**:____ **Date:**___________________

Birth date: ______/________/______ **Age:**______ **Gender:** Female Male

PRESENTING PROBLEM

Why do you **believe mom and/or dad have brought** you to counseling?

____

Describe the **problems you are having** and **when they began**: ____

____

____

MEDICAL HISTORY

1. **List** allergies, serious illnesses, surgeries, injuries, hospitalizations: ____

____

2. My over-all **general health** is: ___Excellent ___Good ___Fair ___Poor

EDUCATIONAL HISTORY

1. What **grade are you in**? ______________________ What school do you attend? ____________________________
2. Do you have any **problems in school**? YES NO If yes, please explain: _________________________________

____

3. Have you ever **repeated** or **skipped** a grade? YES NO Which one? _________________________________
4. Have you ever **dropped out, been expelled,** or **been suspended**? Which one? ____________________________________

What happened? ____

____

5. How has your **attendance** been? ___Excellent ___Good ___Fair ___Poor
6. What are your **grades** like? _________________________________ Have they changed a lot? YES NO
7. Do you have **learning difficulties** or attend **special classes**? YES NO
8. What are your **extra-curricular activities**? ____

____

9. Have you been or are you being bullied? YES NO
10. Would anyone describe you as a bully? YES NO

OCCUPATION

1. Where do you **work**? _______________________________________ **What** do you do and how often do you work?

____

LEGAL HISTORY

1. Are you **currently involved** with the legal system (criminal, divorce, custody, civil, etc.)? **YES** **NO** If so, in what way?

____

____

TREATMENT HISTORY

1. Have you **been in counseling** before? YES NO If so, with whom? ______________________
2. What was the **primary issue**? ______________________

   When? ______________________ For how long? ____________ What was the outcome?

____

3. Have you ever been **hospitalized for emotional problems** or for **alcohol/drug treatment**? YES NO

   If so when? ______________ Where? ______________________What was the outcome?

____

4. What **medications** have you taken **in the past** for **emotional or mental problems**? ______________________

____

5. What medications are you **currently taking** for emotional or mental problems? ______________________

____

____

SOCIAL HISTORY

1. What are your major **strengths**? ______________________

____

2. What are your major **weaknesses**? ______________________

____

3. From whom do you get **emotional support**? ______________________
4. Do you have **friends**? YES NO How do you **get along with** those friends? ______________

   ____

5. Has there been **a change** in your circle of friends lately? YES NO
6. Do your friends tend to **get into trouble**? YES NO
7. Do you **belong to a gang**? YES NO
8. Do any of your **friends belong to a gang**? YES NO
9. Do you have **a belief system** (cultural, moral, spiritual, religious, etc.) which influences your life? Please explain:

____

____

10. Is there **anything about your lifestyle** (or the family's) that would be **helpful for me to know**?

____

____

____

FAMILY HISTORY

1. **Important people in your life** (immediate family/relatives/significant others)

Name	Age	Relationship to You	How do you get along?

______________________ ___ ________________ ____

______________________ ___ ________________ ____

______________________ ___ ________________ ____

2. Your experiences while growing up can affect your life. What **experiences and events** (discipline, favoritism, trauma, affection, lack of attention, etc.) have been **important in your life**? ____

3. Please list your **present and past boyfriend(s)/girlfriend(s).**

First Name	Time Together	Reason for Ending Relationship

SEXUAL HISTORY

1. **Sex Education was delivered by:** _____Home; _____School; _____Friends
2. Are you **currently sexually active**? YES NO Single Partner ________ Multiple Partners ________
   Same Sex Partner ________ Both Sex Partners ________
3. Do you **use Condoms**? YES NO Do you **use Birth Control**? YES NO
4. Have you ever **had a STD** (Sexually Transmitted Disease)? YES NO
   If so what? ____
5. Have you ever been **sexually abused**? YES NO If yes, **by whom** and for what **length of time**?
   ____
6. Has anyone ever **touched you or talked to you sexually** in a way that made you uncomfortable? YES NO

SUBSTANCE USE

SUBSTANCE ABUSE: Do you use **drugs**? YES NO Frequency: Regularly? Occasionally?

How does your **usage affect your life (positively or negatively)**?

____

____

SUICIDE/HOMICIDE

Have you **ever had** or **do you have**? Check all that apply.

	Past	Now
Thoughts of hurting yourself?	______	______
Thoughts of committing suicide?	______	______
Plans to commit suicide?	______	______
Attempts to commit suicide?	______	______
Threats to commit suicide?	______	______
Thoughts of harming someone?	______	______
Plans to harm someone?	______	______
Attempts to harm someone?	______	______
Threats to harm someone?	______	______
Actually harmed someone?	______	______

DEPRESSION

Have **you ever** or **do you now have**? Check all that apply.

	Past	Now
Inability to sleep or sleeping longer?	______	______
Increased or decreased appetite?	______	______
Tearfulness or feelings of despair?	______	______
Lack of energy or feelings of fatigue?	______	______
Preoccupation with life events?	______	______
Decreased contact with others?	______	______
Feelings of depression?	______	______
Decreased interest in pleasurable activities	______	______

Is there **anything else** that may be **helpful for your counselor to know** that we have not asked?

____

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