Alternative Perspectives Counseling, LLC

Adolescent
Questionnaire for new clients

Patient Name: _____

Date: _____

How many sessions are you expecting to need? ☐ 1-10 ☐ 10-20 ☐ ongoing

What are your primary challenges that bring you to therapy?

What are you hoping to gain from therapy?

Circle any of the following abuses your child/dependent has experienced in the past or is currently experiencing: *Physical* *Emotional* *Verbal* *Sexual* *Neglect* *Witness of abuse*

List any current medical conditions/illnesses:

List any current medications: *(or attach list)*

Name	Dose	Frequency	Reason	Physician

List any past mental health or psychiatric history/treatment (i.e., past therapy, issues of self-harm or suicide attempts, use of medications, diagnoses):

List family history of mental health or psychiatric issues involving parents, siblings, grandparents, aunts/uncles (i.e., depression, anxiety, bipolar, suicide attempts):

Describe your child/dependent's strengths and weaknesses:

Name of person completing form:

_____

Parents: **Please check any symptoms or experiences that you have observed in the last month.**

(A second copy of this checklist is included for older children who may wish to report their own observations as well)

	Nightmares		Persistent, repetitive, intrusive thoughts, impulses or images
	Traumatic experience		
	Easily startled, feeling 'jumpy'		Rapid mood changes
	Intrusive memories		Racing thoughts
	Panic attacks		Risky behaviors
	Fear of certain objects or situations (i.e., flying, heights, bugs, etc.)		Binge eating
			Voluntary vomiting
	Feeling numb		Excessive exercise
	Feeling confused as to what is real and unreal		Lying
	Repetitive sounds or body movements (i.e., rocking, vocal sounds)		Manipulation of others to fulfill desires
			Tantrums/angry outbursts
	Repetitive behaviors or mental acts (i.e., counting, checking locks, washing hands)		Acts or threats of violence toward people/animals
	Fixations/Obsessions		Acts of violence toward objects
	Avoiding people, places, activities, or specific things		Unusual sexual behaviors
			Concerns about sexuality or gender identity
	Difficulty making friends		Other:
	Difficulty leaving home		
	Sensory sensitivity		

Name of person completing form:

_____

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