

Pediatric Behavioral Health, LLC  
Initial Questionnaire for Adolescents

Directions: This form is very important to help with the interview and evaluation process. Not all questions apply to all families; just answer questions as best as they apply to your family. Your answers will help us to better address your teen's needs and to better understand your teen. It takes about 15-20 minutes to complete. Thank You.

Demographic Information:

Today's Date: \_\_\_\_\_

Teen's Name: \_\_\_\_\_

Teen's Sex: Male Female

Teen's Date of Birth: \_\_\_\_\_

Teen's Age: \_\_\_\_\_

Teen's School: \_\_\_\_\_

Teen's Grade: \_\_\_\_\_

Teen's Race: \_\_\_\_\_ Height: \_\_\_\_\_

Weight: \_\_\_\_\_

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Mother's Information:

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Mother is:  Biological Parent  Adoptive Parent  Foster Parent

Other \_\_\_\_\_

Marital Status: \_\_\_\_\_

Date of Marriage: \_\_\_\_\_

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Father's Information:

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

Father is:  Biological Parent  Adoptive Parent  Foster Parent  Other \_\_\_\_\_

Marital Status: \_\_\_\_\_

Date of Marriage: \_\_\_\_\_

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Step-Mother Information:

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

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Step-Father Information:

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education: \_\_\_\_\_

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Sibling Information:

Name: _____	Age: _____	Full	Half	Step	Adopted
Name: _____	Age: _____	Full	Half	Step	Adopted
Name: _____	Age: _____	Full	Half	Step	Adopted

List all people with whom the teen lives: \_\_\_\_\_

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Presenting Problem / Referral Question:

Please list the three biggest reasons (or problems) for which you are seeking help for your teen:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Problem History:**

1. Approximately how old was your teen when you first noticed your teen's problem? What did the problem look like then?
  
2. How has your teen's problem changed throughout his/her growth?
  
3. What is your teen's attitude toward his/her problems?
  
4. Has your teen had any other behavioral or emotional problems in the past (even if they are not affecting him/her now)? Describe.
  
5. Previous therapy experiences of your teen (include family, school, therapy and psychiatric medications).

Therapist's Name	Therapy Dates	Clinic Name and Phone #	Reason for Therapy	Effectiveness of Therapy
a. _____				
b. _____				

6. Has your teen ever talked about hurting or killing him/herself or another person? Describe.

7. Who referred you for psychological services? \_\_\_\_\_

8. Do you agree with this referral? YES NO Mixed Feelings

Family Background

1. List marriages of the MOTHER (past and present):

Spouse's Name	Marriage Date	Children's Names	Divorce Date	Reason for Divorce
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. List marriages of the FATHER (past and present):

Spouse's Name	Marriage Date	Children's Names	Divorce Date	Reason for Divorce
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Please indicate if the following have occurred in the family:

	Date(s)	Description / Comments
Divorce	_____	_____
Separation	_____	_____
Marital Problems	_____	_____
Domestic Violence	_____	_____
Excessive Conflict	_____	_____
Death of Parent	_____	_____
Death of Teen	_____	_____
Death of Grandparent	_____	_____
Alcohol Abuse by Parent	_____	_____
Drug Abuse by Parent	_____	_____
Move to New Home	_____	_____
Physical or Sexual Abuse	_____	_____
Illness of Family Member	_____	_____
Other Changes	_____	_____



4. How is discipline handled in the family?

5. Who is most responsible for discipline?    Mother    Father    Both

6. Family Religion: \_\_\_\_\_

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Developmental History:

1. Were there any complications with the pregnancy or delivery of your teen?    YES    NO  
If yes, describe:

2. Did / Does you teen have any developmental delays (e.g., late walking, talking, etc.)?    YES    NO  
If yes, describe:

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Medical History:

1. Current Medications that your teen is taking:

Name	Dose	Times Per Day	Reason
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____

2. Past medications that your teen has taken for behavior or psychological problems (list name only):

a. \_\_\_\_\_    b. \_\_\_\_\_    c. \_\_\_\_\_

3. Has your teen ever used or abused medication, illegal drugs, or alcohol?    YES    NO  
If yes, describe,

4. Allergies:

Allergy	Typical Reaction
a. _____	_____
b. _____	_____

5. Serious and/or life-threatening illnesses:

	Date	Illness	Consequences
a.	_____		
b.	_____		

6. Major Injuries:

	Date	Injury	Consequences
a.	_____		
b.	_____		

7. Major Hospitalizations:

	Dates	Reason for Hospitalization
a.	_____	
b.	_____	

8. Surgeries:

	Date	# Days Hospitalized	Reason for Surgery
a.	_____		
b.	_____		

9. Exposure to Poisons or Toxic Substances:

	Date	Substance	How Exposed (i.e. Drank)	Effect on Teen
a.	_____			
b.	_____			

10. Does anyone in the teen's immediate or extended family have the following illnesses or problems? Include brothers, sisters, father, mother, grandparents, aunts, uncles, cousins.

<u>Illness</u>	<u>Circle Y or N</u>		<u>Relationship to the Teen (i.e., aunt, father, etc.)</u>
Depression	Y	N	_____
Manic Depression	Y	N	_____
Nervous Breakdown	Y	N	_____
Psychiatric Hospitalization	Y	N	_____
Delayed Reading	Y	N	_____
Delayed Speech	Y	N	_____

Illness	Circle Y or N	Relationship to the Teen (i.e., aunt, father, etc.)
Mental Retardation	Y N	_____
Attention Problems	Y N	_____
Hyperactivity	Y N	_____
Heavy Drinking	Y N	_____
Drug Abuse	Y N	_____
Suicide	Y N	_____
Stealing	Y N	_____
School Phobia	Y N	_____
Epilepsy	Y N	_____
Felony Conviction	Y N	_____
Anxiety Disorder	Y N	_____
Schizophrenia / Psychosis	Y N	_____
Autism / Asperger's Disorder	Y N	_____
Eating Disorder	Y N	_____
Insomnia	Y N	_____
Any Genetic Disorder	Y N	_____
Other _____	Y N	_____

Social History:

1. How does your teen get along with non-parent adults (check all that apply)?

- |  |   |
|--|---|
| <input type="checkbox"/> Friendly      | <input type="checkbox"/> Better behaved than with parents |
| <input type="checkbox"/> Cooperative   | <input type="checkbox"/> Adults like my teen              |
| <input type="checkbox"/> Disobedient   | <input type="checkbox"/> Obedient                         |
| <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Other _____                      |

2. How does your teen get along with teachers / coaches?

<input type="checkbox"/> Friendly	<input type="checkbox"/> Better behaved than with parents
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Adults like my teen
<input type="checkbox"/> Disobedient	<input type="checkbox"/> Obedient
<input type="checkbox"/> Disrespectful	<input type="checkbox"/> Other _____

3. How does your teen get along with brothers and sisters?

<input type="checkbox"/> Likes them	<input type="checkbox"/> Protective of them
<input type="checkbox"/> They like him/her	<input type="checkbox"/> Aggressive / Fights
<input type="checkbox"/> Jealous	<input type="checkbox"/> Won't share things
<input type="checkbox"/> Ignores them	<input type="checkbox"/> Wants to be babied
<input type="checkbox"/> Other _____	

4. Please list the extracurricular activities your teen is involved with (e.g., sports or clubs):

5. How much time does your teen spend with friends outside of school? \_\_\_\_\_

How much time does your teen spend on the phone with peers? \_\_\_\_\_

How much time does your teen spend communicating with peers on the internet? \_\_\_\_\_

Does your teen have a best friend?    YES    NO

6. How old was your teen when s/he started dating? \_\_\_\_\_ <sup>†</sup> Not yet dating

Is s/he currently in a relationship?    YES    NO

Is your teen sexually active?    YES    NO

7. Has your teen ever been arrested, accused, or convicted of a crime?    YES    NO

If yes, what crimes?

8. Has your teen been sexually abused?    YES    NO

If yes, Describe

9. Has your teen been physically abused?    YES    NO

If yes, Describe

10. Has your teen been emotionally abused?    YES    NO

If yes, Describe

Academic History:

1. Has your teen ever been held back a grade? YES NO

If so, what grade(s)? \_\_\_\_\_

2. Previous Psychological or Educational Testing of your teen:

	Date	School / Clinic	Reason for Testing	Findings
a.	_____	_____	_____	_____
c.	_____	_____	_____	_____

3. Does/has your teen ever had an IEP (Individual Education Plan) or 504 Plan? YES NO

If yes, Describe

4. Is your teen in any of the following class placements?

\_\_\_\_\_ Resource Room (What subjects? \_\_\_\_\_)

\_\_\_\_\_ Gifted Class (What subjects? \_\_\_\_\_)

\_\_\_\_\_ Special Education Class

\_\_\_\_\_ Emotionally Handicapped (EH or BEH) Class

5. What are your teen's grades in each subject?

6. Have your teen's grades changed over time? YES NO

If yes, describe

7. How is your teen's behavior in school (check all that apply)?

- |                             |                       |
|-----------------------------|-----------------------|
| _____ Disobedient           | _____ Overactive      |
| _____ Worried / tense       | _____ Withdrawn / shy |
| _____ Not liked by peers    | _____ Popular         |
| _____ Not liked by teachers | _____ Class clown     |
| _____ Other _____           |                       |

8. List changes in your teen's school setting during his/her life. Why were these changes made? How did your teen react?

9. Have any of the following happened to your teen at school (check all that apply)?

Suspended

Expelled

Special conference for behavior problems

Switched classes because of problems

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Please provide any additional information that you think would be helpful.