

## Nashville Child and Family Wellness Center

### Adolescent Self-Report Questionnaire

*This form should be filled out in addition to the Adolescent-Young Adult Initial Visit Questionnaire. It is to be completed by the adolescent either before or at the initial visit, whichever the adolescent is most comfortable doing.*

*Understanding as much as possible about you is essential to being able to help you. Please answer these questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you or your situation, please write N/A. This information, like ALL information you provide, is confidential and will be reviewed only by the provider you are scheduled to see or those for whom you give consent to review this.*

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

#### **CURRENT VISIT**

Provider you are scheduled to see: \_\_\_\_\_

Briefly describe your reason for scheduling an appointment: \_\_\_\_\_

What kind of help do you expect to receive? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **FAMILY INFORMATION**

What is your relationship like with your parents? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your relationship like with any other family members? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you experiencing any family difficulties?  No  Yes

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **EDUCATIONAL HISTORY:**

Describe your strengths in school: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you experiencing any difficulties in school?  No  Yes

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your overall performance in school. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **MEDICAL AND MENTAL HEALTH HISTORY:**

Do you have any health problems at this time?  No  Yes

If yes, please explain: \_\_\_\_\_

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Has you previously seen a therapist or psychiatrist?  No  Yes

If yes, when and what was your experience like?

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Have you ever tried to kill yourself or engaged in self-harming behavior (i.e. cutting, head banging, other)?  No  Yes

If yes, please explain: \_\_\_\_\_

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Do you get regular exercise or play sports?  No  Yes

Details: \_\_\_\_\_

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Do you feel that you are:  Underweight  Overweight  Just right

Do you diet on a regular basis?  No  Yes

Are you currently in a relationship?  No  Yes

Are you sexually active?  No  Yes

If yes, any form(s) of contraception used are: \_\_\_\_\_

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Have you ever been sexually, physically, verbally, or emotionally abused (include abuse by family and non-family)?  No  Yes If Yes, please indicate at what age and by whom: \_\_\_\_\_

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### **Questions for females:**

Have you started your period yet?  No  Yes

If yes, how old were you when you had your first period? \_\_\_\_\_

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First day of last menstrual period (LMP) was: \_\_\_\_\_

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Any problems with your periods?  No  Yes If yes, explain: \_\_\_\_\_

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### **SPEECH/LANGUAGE SECTION**

Do you have trouble finding the exact words to say when speaking or writing?

No  Yes If yes, how early? \_\_\_\_\_

Is it hard for you to follow complex directions?

No  Yes If yes, how early? \_\_\_\_\_

Is it difficult for you to keep information in your memory long enough to complete a task? (i.e. a math problem, shopping list)

No  Yes If yes, how early? \_\_\_\_\_

Do you have difficulty understanding jokes, humor, and figurative language?

No  Yes If yes, how early? \_\_\_\_\_

Do you have difficulty interacting with others like starting a conversation, maintaining a conversation or ending a conversation?

No  Yes If yes, how early? \_\_\_\_\_

Do you have difficulty keeping yourself organized?

No    Yes   If yes, how early? \_\_\_\_\_

**SOCIAL HISTORY:**

Please describe your friend group: \_\_\_\_\_  
\_\_\_\_\_

What do you like to do with your friends? \_\_\_\_\_  
\_\_\_\_\_

Are you having any problems with your friends?  Yes    No    Possibly    Not sure

Details: \_\_\_\_\_

Please describe your current or past use of alcohol and/or drugs: \_\_\_\_\_  
\_\_\_\_\_

Do you have a job?  No    Yes   If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

What do you like to do in your free time? \_\_\_\_\_  
\_\_\_\_\_

What do you consider to be your strengths? \_\_\_\_\_  
\_\_\_\_\_

List any major life stressors (e.g., death of family member, unemployment, major accident, house fire, crime victim, etc.) that you or your family has faced during your life and how old you were at the time:

\_\_\_\_\_  
\_\_\_\_\_

List any other significant life influences, events, or traumas: \_\_\_\_\_  
\_\_\_\_\_

Any other comments? \_\_\_\_\_  
\_\_\_\_\_

**REFERRAL INFORMATION**

Referral Source: \_\_\_\_\_ Relationship: \_\_\_\_\_

May I contact them about your consultation with me?  Yes    No

Reason for Referral:

\_\_\_\_\_  
\_\_\_\_\_

## CURRENT SYMPTOM CHECKLIST

*Please place a check mark in the box next to any symptom you are currently experiencing or have experienced in the past few weeks.*

- Sleep problems
- Sleep too much
- Nightmares or night terrors
- Feel a sense of dread
- Feel I have no future
- Isolation/social withdrawal
- Mood swings
- Lower sex drive
- Agitation or nervousness
- Muscle tension or soreness
- Stomach nausea or upset
- Having to check and re-check
- Worry about what others think
- Compare self to others
- Obsessive thoughts
- Compulsive behaviors
- Feel my life is out of control
- Afraid something is wrong w/ me
- Faintness or dizziness
- Easily annoyed or irritated
- Pain in heart or chest
- Feel over-sensitive
- Heart pounds or races
- Feel inferior to others
- Difficulty making decisions
- Afraid to go out in public
- Avoid certain things
- Have frightening/disturbing thoughts
- Feel something bad will happen
- Have unfounded fears
- Worry a lot
- Feel hopeless/helpless
- Appetite changes
- Excessive behaviors (spending, gambling, etc)
- Racing thoughts
- Frequent headaches
- Feel panicky or terrified
- Uncomfortable memories
- Feel disconnected from reality
- Dislike my body
- Feel guilty or ashamed
- Cry often
- Feel life is not worth living
- Temper outbursts
- Low energy
- Withdrawn socially
- Body aches and pains
- Feel lonely
- Perfectionist
- Shortness of breath
- Enjoy things less
- Self-conscious
- Fearful when driving
- Trouble concentrating
- Feel worthless
- Argumentative
- Dislike crowds
- Difficulty remembering things
- Feel suicidal
- Low self-esteem
- Stress or tension
- Thoughts of hurting yourself
- Thoughts of hurting someone
- Cutting or self-injury
- Alcohol or drug use
- Prescription drug abuse
- Anger management
- Blackouts
- Eating concerns/body image
- Depression/sadness
- Other (list below)

*Please list any other symptoms that would be helpful for me to know:*