

**CEDAR CREEK ASSOCIATES**  
**Private, Independent Practitioners**

**ADOLESCENT QUESTIONNAIRE**

**PERSONAL INFORMATION:**

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

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Please list any person living in your home:

| Name  | Age   | Relationship | Quality of Relationship |
|-------|-------|--------------|-------------------------|
| _____ | _____ | _____        | _____                   |
| _____ | _____ | _____        | _____                   |
| _____ | _____ | _____        | _____                   |
| _____ | _____ | _____        | _____                   |

Please list other immediate family members not currently living in your home:

| Name  | Age   | Relationship | Quality of Relationship |
|-------|-------|--------------|-------------------------|
| _____ | _____ | _____        | _____                   |
| _____ | _____ | _____        | _____                   |
| _____ | _____ | _____        | _____                   |
| _____ | _____ | _____        | _____                   |

Mother's occupation: \_\_\_\_\_

Father's occupation: \_\_\_\_\_

Family's religion: \_\_\_\_\_

Do you attend? \_\_\_\_\_

Were you adopted? \_\_\_\_\_

If so, at what age? \_\_\_\_\_

Have you had any contact with your biological parents since the adoption? \_\_\_\_\_

How do you believe your family manages conflict? \_\_\_\_\_

Are there other family-related issues your therapist might need to know about?

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**EDUCATIONAL INFORMATION:**

School: \_\_\_\_\_

Grade: \_\_\_\_\_

Have you ever failed a

grade or been held back? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Have you ever received special education, special resource, or speech services? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

What activities in and out of school do you do? \_\_\_\_\_  
\_\_\_\_\_

What kind of grades do you typically make? \_\_\_\_\_

**MEDICAL INFORMATION:**

Physician: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Please list any illnesses or medical conditions: \_\_\_\_\_

Please check and explain any concerns or events from the list below:

\_\_\_\_\_ Your weight or diet: \_\_\_\_\_

\_\_\_\_\_ Weight loss or gain of more than five pounds in the past year? \_\_\_\_\_

\_\_\_\_\_ Have you ever been unconscious from a head injury? \_\_\_\_\_

\_\_\_\_\_ Have you ever been neglected, traumatized, or abused? \_\_\_\_\_

\_\_\_\_\_ Have you had previous counseling or testing? \_\_\_\_\_

\_\_\_\_\_ Have you tried, or do you use, dugs, tobacco, or alcohol? \_\_\_\_\_

\_\_\_\_\_ Have you ever received treatment for drug or alcohol use? \_\_\_\_\_

\_\_\_\_\_ Do you drink caffeine (sodas, tea, coffee, energy drinks) and how much? \_\_\_\_\_

\_\_\_\_\_ Have you ever been hospitalized? \_\_\_\_\_

\_\_\_\_\_ Have you ever been the victim of a crime? If so, please explain:  
\_\_\_\_\_

**SOCIAL/RECREATIONAL INFORMATION:**

Please list your hobbies and interests: \_\_\_\_\_

Do you have a best friend? \_\_\_\_\_ Do you have a TV in the bedroom? \_\_\_\_\_

Estimate the number of hours per week you watch TV: \_\_\_\_\_

Estimate the number of hours per week you play video or computer games: \_\_\_\_\_

**PRESENTING PROBLEM:**

Please explain why you are seeking treatment: \_\_\_\_\_  
\_\_\_\_\_

How severe are these concerns to you? \_\_\_\_\_ Mild \_\_\_\_\_ Severe \_\_\_\_\_ Extremely severe

How severe are these concerns to your parents? \_\_\_\_\_ Mild \_\_\_\_\_ Severe \_\_\_\_\_ Extremely severe

When did the problem(s) begin? \_\_\_\_\_

What have you done to try and solve the problems? \_\_\_\_\_

Please check any symptoms you are having:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Tiredness                | <input type="checkbox"/> Difficulty sleeping            | <input type="checkbox"/> Increased tears |
| <input type="checkbox"/> Argues a lot             | <input type="checkbox"/> Loss of interest in activities | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Irritability             | <input type="checkbox"/> Withdrawal from others         | <input type="checkbox"/> Conflicts       |
| <input type="checkbox"/> Worry                    | <input type="checkbox"/> Changed eating habits          | <input type="checkbox"/> Destructive     |
| <input type="checkbox"/> Thoughts of hurting self | <input type="checkbox"/> Thoughts of suicide            | <input type="checkbox"/> Poor attention  |
| <input type="checkbox"/> Aggressive behavior      | <input type="checkbox"/> Thoughts of hurting others     | <input type="checkbox"/> Nightmares      |
| <input type="checkbox"/> Loss of appetite         | <input type="checkbox"/> Grades have dropped            | <input type="checkbox"/> Over sleeping   |
| <input type="checkbox"/> Over-eating              | <input type="checkbox"/> Confusion                      | <input type="checkbox"/> Can't focus     |
| <input type="checkbox"/> Poor concentration       | <input type="checkbox"/> Memory problems                | <input type="checkbox"/> Depressed       |
| <input type="checkbox"/> Increased anxiety        | <input type="checkbox"/> Panic attacks                  | <input type="checkbox"/> Feel paranoid   |
| <input type="checkbox"/> Other: _____             |   |  |

Please check any recent check any recent changes you have experienced:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Illness or injury                 | <input type="checkbox"/> Family moved                      | <input type="checkbox"/> Friend moved     |
| <input type="checkbox"/> Sibling left home                 | <input type="checkbox"/> New family member                 | <input type="checkbox"/> Parent left home |
| <input type="checkbox"/> Loved one died                    | <input type="checkbox"/> Experienced or witnessed violence | <input type="checkbox"/> Parents divorced |
| <input type="checkbox"/> Child moved into/away from family |  |   |
| <input type="checkbox"/> Other major loss or event: _____  |  |   |
| <input type="checkbox"/> Other: _____                      |  |   |

**Thank you. Your therapist will be happy to answer any questions or address any concerns you have about these questions.**