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: _____

_____

Has you previously seen a therapist or psychiatrist? ☐ No ☐ Yes

If yes, when and what was your experience like?

_____

_____

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: _____

_____

Do you get regular exercise or play sports? ☐ No ☐ Yes

Details: _____

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: _____

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:_____

_____

Questions for females:

Have you started your period yet? ☐ No ☐ Yes

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

First day of last menstrual period (LMP) was: _____

Any problems with your periods? ☐ No ☐ Yes If yes, explain: _____

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: