

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: _____

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.

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 Withdrawn socially |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

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