**BALANCE BEHAVIORAL HEALTH, PLLC**

# ADOLESCENT QUESTIONNAIRE

Please answer the following questions as completely as possible

Child's Name _____ M ___ F ___ Birth Date_____

Today's Date_____ Form completed by_____

Your relationship to the child_____

Child's School_____ Grade_____

Child's Primary Physician_____ Phone_____

When did your child last see a physician?_____ The reason?_____

_____

Does your child have any chronic or serious illnesses? If so, please describe:_____

_____

List any medications your child is regularly taking, or has taken:

NAME DOSAGE FREQUENCY DATE STARTED/ENDED MD

_____

_____

_____

Has your child ever been hospitalized? If yes, briefly explain: _____

_____

FAMILY INFORMATION:

Mother's Name_____ Birthdate_____

Mother's Occupation_____ Education_____

Living in Home? Yes_____ No_____ If no, please explain_____

_____

Father's Name_____ Birthdate_____

Father's Occupation_____ Education_____

Living in Home? Yes_____ No_____ If no, please explain_____

_____

With whom does the child live? Birth parents_____ Foster Parents_____ Adoptive Parents_____

Other (specify)_____

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List all other persons living in the home:

| NAME | DOB | RELATIONSHIP TO CHILD | SEX | GRADE/JOB |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

List any other people who care for the child a significant amount of time (neighbor, babysitter, grandparent, etc.)

| NAME | RELATIONSHIP TO CHILD |
|---|---|
| | |
| | |

Please list any jobs or chores your Child has in the family or at school. (feeding the dog, taking out trash, Safety patrol). If none_____

How well does your child do these jobs or chores?

Poor 1 2 Average 3 4 Great 5

1. _____ _____
2. _____ _____
3. _____ _____

Comments_____

What is your child's preferred gender_____ Preferred pronouns: _____

Compared to other children his/her age, how does your child get along with other children?

Poor 1 2 Average 3 4 Great 5

What are your child's favorite recreational or extracurricular activities? _____

Who generally disciplines the child? _____

What methods are used?_____

Do parents agree about method of discipline? Yes_____ No_____ If no, please explain: _____

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If your child has been to school (including preschool, kindergarten, elementary, etc.), complete the following for all classes and end with the current placement. Please comment if your child repeated a grade or is in a special class (gifted, learning disabled, curriculum assistance, behaviorally/emotionally handicapped, etc.)

GRADE SCHOOL COMMENTS

_____

_____

_____

_____

_____

Current school performance (for children aged 6 and older):

| | Failing | Below Average | Average | Above Average |
|---|---|---|---|---|
| Reading | _____ | _____ | _____ | _____ |
| Writing | _____ | _____ | _____ | _____ |
| Math | _____ | _____ | _____ | _____ |
| Spelling | _____ | _____ | _____ | _____ |

Other academic subjects (History, Science, Art, Music, Languages, etc.)

| | Failing | Below Average | Average | Above Average |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Behavior problems in school? _____

_____

PARENT CONCERNS:

What do you think is your child's main problem? _____

_____

_____

_____

When did these problems begin? _____

_____

What do you think caused your child's problem(s)?_____

_____

_____

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What have you been told by doctors, teachers, and/or others about your child's problem(s)?_____

_____

Has this child had any other mental health evaluations or treatment?_____

_____

_____

Educational evaluations, occupational or physical therapy, or speech or language evaluations?_____

_____

Has any other member of the child's immediate family had mental treatment?_____

_____

Please describe any marital problems or family stresses which may contribute to your child's problem:_____

_____

_____

What has been done so far to try to deal with your child's problems?_____

_____

_____

Please list any special strengths or talents that your child has: _____

_____

_____

Any other information that you think may be helpful about your child:

_____

_____

_____

_____

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## Symptom Checklist

Please check all of the following problems/symptoms which pertain to your child.

( ) panicky feelings
( ) nervousness
( ) anxiety
( ) fears
( ) phobic avoidance
( ) procrastination
( ) nervous tics
( ) driven to perform certain behaviors
( ) headaches
( ) chest pains
( ) rapid heart beat
( ) dizziness
( ) excessive sweating
( ) appetite problems
( ) weight loss/gain
( ) bowel/stomach trouble
( ) binging
( ) vomiting
( ) purging
( ) muscle tension
( ) physical pain
( ) hearing problems
( ) menstrual problems
( ) sexual problems
( ) drug/alcohol abuse
( ) depression
( ) unhappiness
( ) seasonal variations in mood
( ) tearfulness
( ) loss of interest
( ) sleep problems
( ) nightmares
( ) fatigue
( ) low self-esteem
( ) memory problems
( ) reduced concentration
( ) withdrawal
( ) no sense of purpose
( ) shyness
( ) loneliness
( ) relationship problems
( ) job problems
( ) educational problems
( ) financial problems
( ) career issues
( ) boredom
( ) temper outbursts
( ) anger problems
( ) loss of control
( ) suspicious of others
( ) hearing unidentified voices or sounds
( ) guilt
( ) jealousy
( ) difficulty making decisions
( ) homicidal thoughts
( ) suicidal thoughts
( ) history of abuse
( ) flashbacks
( ) time loss
( ) feeling out of body
( ) feeling unreal
( ) smelling unidentified odors
( ) sensitivity to noise or lights
( ) racing thoughts

**THANK YOU FOR YOUR TIME AND COOPERATION!**