CENTRAL MINNESOTA MENTAL HEALTH CENTER
Adolescent Questionnaire

Feel free to ask your therapist if you need help with completion of this form or have questions about it.

Today's Date: _____

Identifying and Contact Information:

Name: _____ Age: _____ Date of Birth: _____

Identity Considerations:

Race/culture: _____

Gender: _____

Pronouns (he/she/they): _____

Sexual Orientation: _____

Spirituality/religion: _____

Y/N I would like things regarding my identity integrated into therapy.

◯ Yes ◯ No

Who all lives in your house? _____

Current Concerns:

Stressors: (transitions/losses/trauma/difficult changes)
Have you experienced any of the following and if so, what age were you?

☐ Recent move or change in school _____Age
☐ Lack of friends _____Age
☐ Recent change in friends _____Age
☐ Bullying _____Age
☐ Being separated from caretaker _____Age
☐ Death of a caretaker _____Age
☐ Death of close friend/relative _____Age
☐ Death of a pet _____Age
☐ Caretakers separating or divorce _____Age
☐ New person moved into your home _____Age
☐ Accident or serious injury _____Age
☐ Experienced (physical, sexual, or emotional) abuse _____Age
☐ Witnessed violence toward family members _____Age

Occupation/Work:
Do you have a job? Yes ◯ No ◯

Employer:_____

Position Title: _____

Length of time with employer:_____

Education:
What grade are you in? _____What school do you attend? _____

Any school related concerns? ◯ **No** ◯ **Yes** **If yes, please describe:**

Attendance_____
Behaviors_____
Grades _____

Physical Health/Self Care:
Do you or others have any concerns with your physical health/self-care?

◯ No ◯ Yes **If yes, please describe:**

How many hours do you spend on screen time (e.g., T.V., phones, other electronic devices) outside of school?

_____

Head injury/concussion _____

Vision/Hearing problems _____

Weight/Eating problems _____

Are you sexually active? Yes ◯ No ◯

Have you had any pregnancies? Yes ◯ No ◯

Do you have children? Yes ◯ No ◯ If yes indicate number and ages? _____

Do they live with you? Yes ◯ No◯

Legal:

Please list or describe any current/pending legal issues:

_____

_____

Name of Probation Officer: _____ Release signed: ◯ Yes ◯ No

Briefly identify any past legal problems involving charges, jail/prison time, court orders, civil commitments:

_____

_____

Kiddie-CAGE:

Have you used more than one chemical at the same time in order to get high? Yes ◯ No ◯
Do you avoid family activities so you can use? Yes ◯ No ◯
Do you have a group of friends who use? Yes ◯ No ◯
Do you use to improve your emotions such as when you feel sad or depressed? Yes ◯ No ◯

Substance Use:

Have you ever used any of these substances? ◯ **No** ◯ **Yes** **If yes, check all that apply.**

☐ Smoking
☐ Alcohol
☐ Cocaine/crack
☐ Heroin
☐ Methamphetamines
☐ Sleeping pills
☐ Diet pills
☐ Speed
☐ LSD/acid/angel dust
☐ Marijuana
☐ Prescription drugs/over the counter
☐ Other

Have you ever had chemical dependency treatment? ◯ No ◯ Yes **If yes, please describe**

_____

_____

Mental Health History:

Do you have any mental health concerns you would like to address in therapy? ◯ **No** ◯ **Yes**

If yes, please describe:

_____

Have you ever experienced any of the following? ◯ **No** ◯ **Yes** **If yes, check all that apply:**

_____

☐ Wishing you were dead/suicidal thoughts/attempts
☐ Self-harm

There is something I want to talk about that I do not want to write on this form Yes ◯ No ◯

***Thank you* for your time and effort in completing this form. The information you have supplied will be very helpful to us in our effort to provide you with the services required.**