

CLIENT QUESTIONNAIRE

Teen intake form

SUE MAYO, MFT

3184 Old Tunnel Road, Suite D • Lafayette, Calif. 94549

NAME		BIRTH DATE	AGE
ADDRESS (STREET)	CITY	ZIP	PHONE NUMBER

WHOSE IDEA WAS IT FOR YOU TO BE SEEN HERE TODAY? Mine Parent(s) Other

IF SOMEONE OTHER THAN YOU, ARE YOU OKAY WITH THIS IDEA? No Yes Not sure

MAIN PROBLEM/MAJOR REASONS FOR SEEKING HELP NOW:

WITH WHOM DO YOU LIVE? Both parents Mother Father

Other: _____

PLEASE DESCRIBE HOW OFTEN YOU HAVE CONTACT WITH YOUR BIOLOGICAL PARENTS:

MOTHER

- Daily Never
 Once per year Monthly
 Weekly Other: _____

FATHER

- Daily Never
 Once per year Monthly
 Weekly Other: _____

PLEASE DESCRIBE YOUR FAMILY BY PLACING A CHECK IN THE APPROPRIATE BOX:

	MOTHER	FATHER	STEPMOTHER	STEPFATHER	Other: _____
Likes me					
Kind/Pleasant/Understanding					
Strict/Mean					
Uses drugs or alcohol					
Disciplines (e.g., grounds, takes away privileges)					
Spanks/Hits					

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Please check the box or boxes below that most closely describe you.

Please use the blank line to provide additional information.

- TOTAL NUMBER OF FRIENDS I HAVE None A few Average A lot
- NUMBER OF BEST FRIENDS 0 1 2-3 4 or more
- HOW I GET ALONG WITH PEERS Poor Average Good Unknown
- HOW I GET ALONG WITH SIBLINGS Poor Average Good N/A
- HOW I GET ALONG WITH PARENTS/GUARDIANS Poor Average Good Unknown

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- SCHOOL PERFORMANCE Poor Average Good
- SCHOOL PROBLEMS (check all that apply) Problems with classmates/bullying Problems with teachers
- Learning problems Detentions
- Lifetime suspensions/expulsions (# _____)
- Other school problems: _____
- _____
- _____

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- CHILD ABUSE (current or past) None Physical Sexual Emotional Neglect
- SUBSTANCE USE (current or past) None Alcohol Marijuana Tobacco/Cigarettes
- Other drugs: _____

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- EXERCISE PER WEEK (average hours) 0 1 2-3 4 or more
- MEDIA USE PER DAY (average hours) 0 1 2-3 4 or more
(e.g., video games, computer, television)
- SLEEP PER NIGHT (average hours) less than 5 6-7 8-10 11-12

BOYFRIEND/GIRLFRIEND No Yes, age _____

SEXUALLY ACTIVE No Yes

SEXUAL PREFERENCE/ORIENTATION _____

PREGNANCY (PAST OR CURRENT) No Yes

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TEEN MOOD SELF-REPORT

Below is a list of some of the ways that you may have felt or acted. Please indicate how often you felt this way during the past week by checking the corresponding box. Please check only one box per item.

<i>During the past week:</i>	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moderate amount of time (3–4 days)	All of the time (5–7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt like I could not shake off the blues even with help from my family or friends.				
4. I felt like I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt people disliked me.				
20. I could not get "going."				
				SCORE = <input type="text"/>

Have you had any of the following thoughts or feelings, *now* or in the *past*?

	Never or not at all	Sometimes	Often	All the time
I felt helpless or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't enjoy things like I used to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel it is too painful to keep living.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel my family would be better off if I were dead.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think about suicide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have thought about specific ways to kill myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Please check the items below that are *current* or *past* problems for you.

- | | |
|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Sad or depressed mood | <input type="checkbox"/> Fatigue or loss of energy |
| <input type="checkbox"/> Irritable or grouchy | <input type="checkbox"/> Loss of interest, pleasure, or motivation |
| <input type="checkbox"/> Problems sleeping (falling or staying asleep) | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Self-harm or self-injurious behaviors (e.g., cutting) | <input type="checkbox"/> Thoughts about homicide or harming others |
| <input type="checkbox"/> Thoughts about suicide or harming myself | <input type="checkbox"/> Hearing voices or seeing things that are not there |
| <input type="checkbox"/> Frequent headaches, stomachaches, or other pains | <input type="checkbox"/> Exposure to a traumatic event (e.g., car accident, death, earthquake) |
| <input type="checkbox"/> Anxiety or worry (e.g., about past behaviors, future events, doing well) | <input type="checkbox"/> Thoughts/ideas that repeat over and over in your head |
| <input type="checkbox"/> Phobia or extreme fear (e.g., scared of flying, heights, going over bridges) | <input type="checkbox"/> Behaviors that you feel you have to do over and over (e.g., counting, washing) |
| <input type="checkbox"/> Make careless mistakes | <input type="checkbox"/> Act without thinking |
| <input type="checkbox"/> Problems paying attention /staying focused | <input type="checkbox"/> Restless/unable to sit still |
| <input type="checkbox"/> Often do not finish homework or chores | <input type="checkbox"/> Talk a lot |
| <input type="checkbox"/> Problems with organization | <input type="checkbox"/> Problems waiting my turn |
| <input type="checkbox"/> Lose things easily | <input type="checkbox"/> Interrupt others |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Blame others for my mistakes | <input type="checkbox"/> Back talk or argue with adults |
| <input type="checkbox"/> Angry most of the time | <input type="checkbox"/> Enjoy "bugging" people |
| <input type="checkbox"/> Easily annoyed by others | <input type="checkbox"/> Lose temper |
| <input type="checkbox"/> Go against adult requests or rules | <input type="checkbox"/> Desire to hurt others or get revenge |
| <input type="checkbox"/> Bully or threaten others | <input type="checkbox"/> Broke into a house, building, car |
| <input type="checkbox"/> Get in physical fights | <input type="checkbox"/> Stay out all night |
| <input type="checkbox"/> Stole things | <input type="checkbox"/> Ran away |
| <input type="checkbox"/> Forced someone into sexual activity | <input type="checkbox"/> Skip school |
| <input type="checkbox"/> Set a fire | <input type="checkbox"/> Problems with the law or police |
| <input type="checkbox"/> Destroyed property | <input type="checkbox"/> Hurt animals |
| <input type="checkbox"/> Fear of weight gain or being fat | <input type="checkbox"/> Overeat/binge |
| <input type="checkbox"/> Trying to lose weight | <input type="checkbox"/> Use of diet pills, laxatives, excessive exercise |
| <input type="checkbox"/> Unhappy with body weight or shape | <input type="checkbox"/> Purging/self-induced vomiting |

PLEASE DESCRIBE YOURSELF:
