Peltier Family Counseling, PLLC
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Adolescent Questionnaire

Name: _____ Gender: _____ Age: _____

Answer as many of these questions as you feel comfortable. Whatever information you chose to give me will help me know more about you, from you, rather than just relying on what your parents say about you. If you prefer to not answer certain questions or if you prefer to not answer any questions, that is fine. This is optional.

How do you feel about being here?
( ) It's fine with me. ( ) I don't care either way. ( ) I'm against it.
Have you ever been to a counselor before? ( ) Yes ( ) No
What events or problems have caused you to come for counseling? _____
_____
_____

Check all that apply to you:
( ) I have difficulty falling asleep.
( ) I wake up frequently during the night.
( ) I wake up very early and can't get back to sleep.
( ) I'm tired much of the time.
( ) I sometimes eat way too much or feel my eating is out of control.
( ) I sometimes vomit after eating too much to get rid of the food.
( ) I worry a lot about the way my body looks.
( ) I have stomach aches or headaches a lot.
( ) I have thoughts that bother me sometimes.
( ) I have a hard time concentrating.
( ) I worry a lot.
( ) I sometimes wish I didn't have to go on living.

Check below the feelings you have most often:

( ) Angry	( ) Happy	( ) Bored	( ) Confident
( ) Grumpy	( ) Sad	( ) Nervous	( ) Worthless
( ) Confused	( ) Depressed	( ) Scared/Afraid	( ) Hopeful
( ) Lonely	( ) Shy	( ) Guilty	( ) Hyper

Check below any problems you are experiencing:

( ) Depression	( ) Eating Problems	( ) Anxiety/Worry
( ) Body Image Issues	( ) Mood Swings	( ) Abuse (current or past)
( ) Grades/School	( ) Sexual Concerns	( ) Parents
( ) Anger Problems	( ) Friends	( ) Siblings
( ) Drug/Alcohol	( ) Self-injury	( ) Other: _____

Are you currently taking any medication? _____

School

What school do you go to? _____
What grade are you in? _____
What do you like about school? _____
What don't you like about school? _____
What kind of grades do you make? _____

Friends and Relationships

How much time to you spend with friends your age? ( ) a lot ( ) some ( ) not much
Do you have a best friend? ( ) Yes ( ) No
If yes, what is his/her name and how long have you known him or her? _____
_____
Do you have a boyfriend or girlfriend? ( ) Yes ( ) No
If yes, what is his or her name and how long have you been dating? _____
Are you sexually active? ( ) Yes ( ) No
Do you have someone you can talk to about personal issues in your life? _____
_____
Do you find it easy or hard to make friends? _____

Activities and Interests

What do you like to do for fun? _____
_____
Are you in any activities (either in school or out of school?) If yes, what? _____
_____

Adults

Check below words to describe what you think of adults:

( ) Helpful	( ) Out of touch	( ) Friendly	( ) Caring
( ) Overly strict	( ) Jerks	( )Smart/Wise	( ) Stupid/Dumb
( ) Can be trusted	( ) Hard to trust	( ) Mean	( ) Kind

Drugs/Alcohol

How often do you…	Never	Tried	Rarely	Monthly	Weekly	Daily
Drink?						
Smoke cigarettes?						
Smoke marijuana?						
Use prescriptions?						
Use cocaine/crack?						
Use acid?						
Other drugs used?						

Strengths/Weaknesses

Do you like the person you are? ( ) Yes ( ) No

What are your strengths? _____

_____

What are your weaknesses? _____

_____

Family

Describe your family in a few words: _____

_____

List the members of your family and how you get along with each one:

Name	Relationship	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What would you change about your family if you were given the power to do so? _____

_____

Faith

Do you currently attend a church, synagogue, or mosque? ( ) Yes ( ) No

Are you involved in a religious youth group? ( ) Yes ( ) No

What does God seem like to you? _____

_____

Other

Have you experienced any unusual or traumatic events?

Age	Event
_____	_____
_____	_____
_____	_____

Have you received unwanted sexual touch from another? ( ) Yes ( ) No

Have you ever been the victim of abuse, neglect, or violence? ( ) Yes ( ) No

Have you ever abused another person? ( ) Yes ( ) No

Is there anything else you want me to know about you? _____

_____

Signature: _____ Date: _____