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Adolescent Psychosocial

Name of Child:_____ Sex:_____

Birth Date:_____ Place of Birth:_____ Age:_____

Present School and Grade:_____

Father's Name:_____ Mother's Name:_____

Address:_____ Phone Numbers:_____

_____ Additional #'s _____

Chief Complaint: (please circle all that apply)

Very unhappy	Impulsive	Stealing
Irritable	Stubborn	Lying
Temper outbursts	Disobedient	Sexual trouble
Withdrawn	Infantile	School performance
Daydreaming	Mean to others	Truancy
Fearful	Destructive	Bed-wetting
Clumsy	Trouble with the law	Soiled pants
Overactive	Running away	Eating problems
Slow	Self-mutilating	Sleeping problems
Short attention span	Head banging	Sickly
Distractible	Rocking	Drug use
Lacks initiative	Shy	Alcohol use
Undependable	Strange behavior	Tobacco-use
Peer conflict	Strange thoughts	Suicide- talk
Phobic	Fire setting	

Further explanation of any above mentioned behaviors:

What happened that makes you seek help at this time? (please be specific)

Problems perceived to be ___ very serious __ serious __not serious

What three changes would you like to see in your child?

1.

2.

3.

What two changes would you like to see in yourself?

1.

2.

What two changes would you like to see in your family?

1.

2.

CURRENT FAMILY SITUATION:

Mother: ____ natural ___step ____ relative ___adoptive

Occupation:

Education:

Age:

History of Substance Abuse/Mental Illness:

Father: ___natural ___step ___relative ___adoptive

Occupation:

Education:

Age:

History of Substance Abuse/Mental Illness:

Marital History of parents:

How often do you agree on the ways to manage your son or daughter? In what ways are there disagreements or conflicts?

LIVING ARRANGEMENTS

Number of moves in child's life and how long in current residence:

Has the child ever lived away from home?

What are the major family stresses at the present time?

What are the sources of family income?

BROTHERS AND SISTERS

	NAME	AGE	SEX	GRADE	OCCUPATION	AT HOME?	DRUGS?	PSYCH?	TREATED?
1									
2									
3									
4									

Others living in the home:

HEALTH OF CHILD

Any previous health problems? Any medications? Please list with dose and frequency.

SOCIAL DEVELOPMENT

Any special habits, fears, idiosyncrasies:

Friendships: (How many friends? How well do you know your child's friends and do you approve of them?)

EDUCATIONAL

Academic Achievement: (Please discuss academic trends from the past four years)

Testing, Special Education: (504 Plan or IEP?)

Hobbies and interests: (Please list three activities that are very important to your child)

1.

2.

3.

Please list three consequences you often use as punishment for bad behavior.

1.

2.

3.

Does your child ever make threats when you attempt to punish them? If so, what are these threats?

Juvenile Justice Involvement/Probation:

Employment: (Has your child ever worked? For how long?)

Emergency contact information:

Additional Comments/Concerns: (Anything that you would like to address in therapy? Is there anything about your child or family that you think is important for me to know that was not asked through prior questions?)

_____ _____

Name of person completing questionnaire **Date**

_____ _____

Therapist **Date**