CLIENT QUESTIONAIRRE

Teen intake form

HELEN MUSCOLO, MFT
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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		**FATHER**	
☐ Daily	☐ Never	☐ Daily	☐ Never
☐ Once per year	☐ Monthly	☐ Once per year	☐ Monthly
☐ Weekly	☐ Other: _____	☐ 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

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: _____

_____

_____

CHILD ABUSE (current or past) ☐ None ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect

SUBSTANCE USE (current or past) ☐ None ☐ Alcohol ☐ Marijuana ☐ Tobacco / Cigarettes

☐ Other drugs: _____

EXERCISE PER *WEEK* (average hours)	☐ 0	☐ 1	☐ 2–3	☐ 4 or more
MEDIA USE PER *DAY* (average hours) (e.g., video games, computer, television)	☐ 0	☐ 1	☐ 2–3	☐ 4 or more
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.

During the past week:	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 =	

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.	☐	☐	☐	☐
I don't enjoy things like I used to.	☐	☐	☐	☐
I feel it is too painful to keep living.	☐	☐	☐	☐
I feel my family would be better off if I were dead.	☐	☐	☐	☐
I think about suicide.	☐	☐	☐	☐
I have thought about specific ways to kill myself.	☐	☐	☐	☐

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

- ☐ Sad or depressed mood
- ☐ Irritable or grouchy
- ☐ Problems sleeping (falling or staying asleep)
- ☐ Fatigue or loss of energy
- ☐ Loss of interest, pleasure, or motivation
- ☐ Racing thoughts

- ☐ Self-harm or self-injurious behaviors (e.g., cutting)
- ☐ Thoughts about suicide or harming myself
- ☐ Thoughts about homicide or harming others
- ☐ Hearing voices or seeing things that are not there

- ☐ Frequent headaches, stomachaches, or other pains
- ☐ Anxiety or worry (e.g., about past behaviors, future events, doing well)
- ☐ Phobia or extreme fear (e.g., scared of flying, heights, going over bridges)
- ☐ Exposure to a traumatic event (e.g., car accident, death, earthquake)
- ☐ Thoughts / ideas that repeat over and over in your head
- ☐ Behaviors that you feel you have to do over and over (e.g., counting, washing)

- ☐ Make careless mistakes
- ☐ Problems paying attention / staying focused
- ☐ Often do not finish homework or chores
- ☐ Problems with organization
- ☐ Lose things easily
- ☐ Forgetful
- ☐ Act without thinking
- ☐ Restless / unable to sit still
- ☐ Talk a lot
- ☐ Problems waiting my turn
- ☐ Interrupt others
- ☐ Easily frustrated

- ☐ Blame others for my mistakes
- ☐ Angry most of the time
- ☐ Easily annoyed by others
- ☐ Go against adult requests or rules
- ☐ Back talk or argue with adults
- ☐ Enjoy “bugging” people
- ☐ Lose temper
- ☐ Desire to hurt others or get revenge

- ☐ Bully or threaten others
- ☐ Get in physical fights
- ☐ Stole things
- ☐ Forced someone into sexual activity
- ☐ Set a fire
- ☐ Destroyed property
- ☐ Broke into a house, building, car
- ☐ Stay out all night
- ☐ Ran away
- ☐ Skip school
- ☐ Problems with the law or police
- ☐ Hurt animals

- ☐ Fear of weight gain or being fat
- ☐ Trying to lose weight
- ☐ Unhappy with body weight or shape
- ☐ Overeat / binge
- ☐ Use of diet pills, laxatives, excessive exercise
- ☐ Purging / self-induced vomiting

PLEASE DESCRIBE YOURSELF: