NORTH ALABAMA FAMILY PSYCHIATRY & COUNSELING

NALFPC Therapist

Adolescent Initial Assessment / Patient Questionnaire

Patient Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____/_____/_____

TO BE FILLED OUT BY ADOLESCENTS *12yo and older*, IN ADDITION TO THE PARENT QUESTIONNAIRE:

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or filling in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please describe, in detail, the present problem including when the problem started, how often it occurs and what stressors may contribute to the problem.

_____
_____
_____
_____
_____
_____
_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

- □ Depressed mood
- □ Diminished interests or pleasure
- □ Sleep disturbance
- □ Fatigue
- □ Change in appetite
- □ Hopelessness
- □ Pleasure in few activities
- □ Weight change
- □ Agitation
- □ Excessive worry
- □ I feel like I am losing control.
- □ Irritability
- □ Poor Concentration
- □ Tension
- □ Feelings of panic
- □ Socially withdrawn
- □ Use of alcohol
- □ Use of other drugs
- □ Use of tobacco
- □ Anxiety in social settings
- □ Makes careless mistakes
- □ Does not complete tasks
- □ Difficulty organizing
- □ Forgetful
- □ Confusion
- □ Disorientation
- □ Compulsive checking / counting
- □ Indecisiveness
- □ People talk about me.
- □ Some people want to hurt me.
- □ I feel emotionally distant from others.
- □ I hear voices or sounds others do not hear.
- □ I see things others do not see.
- □ I smell things others do not smell.
- □ Racing thoughts
- □ I do risky or dangerous things.
- □ Oppositional and defiant behavior
- □ Bullying
- □ Gender concerns
- □ I don't like my body.
- □ Binge eating
- □ Self induced vomiting
- □ Laxative abuse
- □ Excessive fasting
- □ Intense fear of weight gain
- □ Impulsive

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□ I think about hurting myself.
□ I have tried to hurt myself.
□ Sometimes I wish I were dead.
□ I think about hurting someone else.
□ Exposed to a significant traumatic event
□ Recurrent distressing dreams

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? □ Yes □ No.

If YES, please answer the following. **If NO**, please skip to the next section.

Do you **currently** feel that you don't want to live? □ Yes □ No

How often do you have these thoughts?_____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

_____

Sexuality:

How would you identify your sexual orientation?

□ straight/heterosexual □ lesbian/gay/homosexual □ bisexual □ transsexual

□ unsure/questioning □ asexual □ prefer not to answer □ other_____

For females only: Date of last menstrual period _____

Are you currently pregnant or do you think you might be pregnant? □ Yes □ No.

Are you planning to get pregnant in the near future? □ Yes □ No

Birth control method_____

How many times have you been pregnant? _____ How many live births? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? □ Yes □ No

If yes, for which substances?_____

If yes, where were you treated and when?_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____

Have you ever felt you ought to cut down on your drinking or drug use? □ Yes □ No

Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No

Have you ever felt bad or guilty about your drinking or drug use? □ Yes □ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? □ Yes □ No

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Do you think you may have a problem with alcohol or drug use? □ Yes □ No
Have you used any street drugs in the past 3 months? □ Yes □ No
If yes, which ones? _____
Have you ever abused prescription medication? □ Yes □ No
If yes, which ones and for how long? _____
_____

Check if you have tried any of the following:

□ Methamphetamine
□ Stimulants (pills)
□ Hallucinogens
□ Synthetic drugs
□ Methadone
□ Tranquilizer/sleeping pills
□ Other _____
□ Cocaine
□ LSD/ PCP
□ Marijuana
□ Pain Killers (not as a prescription)
□ Alcohol
□ Ecstasy

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:
Have you ever smoked cigarettes? □ Yes □ No
Currently? □ Yes □ No
How many packs per day on average? _____ How many years? _____
In the past? □Yes □ No How many years did you smoke? _____ When did you quit? _____
Have you ever used pipes, cigars, or chewing tobacco: Currently? □ Yes □ No In the past? □ Yes □ No
What kind? _____ How often per day on average? _____ How many years? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? □ Yes □ No
If yes, what religion or spiritual group? _____
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? □ more helpful □ stressful