

Adolescent Initial Assessment / Patient Questionnaire
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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:**

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 Socially withdrawn | 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



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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

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? _____



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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:

- | | |
|--|---|
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> Cocaine |
| <input type="checkbox"/> Stimulants (pills) | <input type="checkbox"/> LSD/ PCP |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Marijuana |
| <input type="checkbox"/> Synthetic drugs | <input type="checkbox"/> Pain Killers (not as a prescription) |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Tranquilizer/sleeping pills | <input type="checkbox"/> Ecstasy |
| <input type="checkbox"/> Other _____ | |

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