Highland Park Psychological Services

210 Skokie Valley Road Suite #12 | Highland Park | www.hppsychservices.com | (847) 915- 6078

Teen History and Questionnaire

Please complete this form as accurately and as fully as possible. This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Client Information:

Name:_____Date of Birth:_____ Age:_____

School:_____Grade:_____ Gender:_____ Preferred Pronouns:_____

Home Address:_____

Home#:_____ Cell#:_____
Can we leave a message?_____ Can we leave a message?_____

E-mail:_____ Can we email you?_____
*Please note: E-mail correspondence is not considered to be a confidential medium of communication.

Emergency Contact:_____ Phone: (_____)_____

Family Constellation:
Who lives at home with the you? (please include extended family and pets)

Name:_____Relationship:_____Age:_____

Describe your relationship with this person_____

Name:_____Relationship:_____Age:_____

Describe your relationship with this person_____

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Describe your relationship with this person_____

Name:_____Relationship:_____Age:_____

Describe your relationship with this person_____

Name:_____Relationship:_____Age:_____

Describe your relationship with this person_____

Please list any other family members that you are close to that don't live with you:

Name:_____Relationship:_____Age:_____

Describe your relationship with this person_____

Name:_____Relationship:_____Age:_____

Describe your relationship with this person_____

Please describe any important family events (e.g., divorces, remarriages, deaths, traumas, losses, significant moves, etc) that have occurred in the last 10 years:_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific heath problems you are currently experiencing:

   _____

2. How would you rate your current sleep habits?

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are currently experiencing:

   _____

3. How many times a week do you generally exercise? _____

   What types of exercise do you participate in?_____

4. Please list any difficulties you experience with your appetite or eating patterns:

   _____

5. Are you currently experiencing overwhelming sadness, grief or depression?_____

   If yes, for how long?_____

6. Are you currently experiencing anxiety, panic attacks, or have any other phobias?_____

   If so, what is the general cause of these attacks?_____

   How often do they occur (# times per week or day)_____

7. Are you currently experiencing chronic pain?_____

   If yes, please describe: _____

8. Do you have any other health issues?

9. Are you currently on any non-psychiatric medications?

   If yes, please list the name of the medication(s) and reason(s) for taking.

10. Have you ever been prescribed psychiatric medication? yes no

    If yes, please provide name of medication(s) and reason (s) for taking:

    Name of prescribing doctor:

    .

11. Do you **currently** take any psychiatric medication? yes no

    *If yes, please fill out a release form so we may coordinate your care with the prescribing physician

12. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc)?

    If so, please provide:

    Name Therapist/Practitioner:_____Dates of service:_____

    Main focus of therapy:_____

    Was it effective?_____

    Why or Why Not?_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

History of:	Yes / No	Family member
Alcohol/Substance		
Abuse		
Anxiety		
Depression		
Domestic Violence		
Eating Disorders		
Obesity		
Obsessive/Compulsive Behavior Schizophrenia		
Suicide Attempts		

ADDITIONAL INFORMATION:

1. On a scale of 1-10 how much do you stress about?
   - Family?_____
   - Social Scene?_____
   - Friends?_____
   - Romantic Relationships._____
   - Academics_____
   - Future_____
   - Self-Image_____
   - Body Image_____
   - Anything else?_____

2. What significant life changes or stressful events have you experienced recently? _____

   _____

3. Why are you seeking therapy at this time?_____

   _____

4. What do you hope to get out of therapy?_____

PERSONAL STRENGTHS

What do you consider to be some of your strengths?_____

_____

What do you consider to be some of your weaknesses?_____

_____

What types of things do you enjoy doing in your spare time?_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life?

(Please describe) _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes _____No

If yes, how often do you drink? _____Daily _____Weekly _____Occasionally _____Rarely

If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes _____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes _____No

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go?_____. ____Inpatient ____Outpatient

ADOLESCENTS (please answer the following with Y/N)

Have you ever used more than 1 chemical at the same time to get high? _____

Do you avoid family activities so you can use? _____

Do you have a group of friends who also use? _____

Do you use to improve your emotions such as when you feel sad or depressed? _____

FAMILY HISTORY

Are your parents married or divorced? _____

Do you think their relationship is good? (Y/N/Unsure)_____

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home?

Please describe as much as you feel comfortable.

FAMILY CONCERNS (Please circle any family concerns that your family is currently experiencing)

Fighting Disagreeing about relatives Feeling Distant Disagreeing about friends Loss of fun Alcohol use

Lack of honesty Drug use Physical fights Infidelity Education problems Divorce/separation

Financial problems Issues regarding remarriage Death of a family member Birth of a sibling

Abuse/neglect Birth of a child Inadequate housing/feeling unsafe Inadequate health insurance

Job change or job dissatisfaction Other concerns not listed above _____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.

Are you happy with the amount of friends you have? (Y/N)_____

Have you ever been bullied? (Y/N) _____

Are your parents happy with your friends? (Y/N)_____

Are involved in any organized social activities (e.g. sports, scouts, music)?

_____

SCHOOL HISTORY

Do you like school? (Y/N)_____

Do you attend regularly? (Y/N)_____

What are your current grades? _____

Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know?_____

_____

_____

Check the box to indicate if you have experienced any of the following symptoms in the past 6 months and the severity with which they have occurred. If you are aware of the cause of the symptom, please list that as well

SYMPTOM	NONE	MILD	MODERATE	SEVERE	PRIMARY CAUSE:
SADNESS					
APPETITE CHANGES					
CRYING					
SOCIAL ISOLATION					
SLEEP DISTRUBANCES					
PARANOID THOUGHTS					
PROBLEMS AT HOME					
POOR CONCENTRATION					
HYPERACTIVITY					
INDECISIVENESS					
BINGING/PURGING					
LOW ENERGY					
LONELINESS					
EXCESSIVE WORRY					
UNRESOLVED GUILT					
LOW SELF WORTH					
IRRITABILITY					
ANGER ISSUES					
NAUSEA/INDIGESTION					
SPIRITUAL CONCERNS					
SOCIAL ANXIETY					
HALLUCINATIONS					
SELF MUTALATION					
RACING THOUGHTS					

SYMPTOM	NONE	MILD	MODERATE	SEVERE	PRIMARY CAUSE:
CUTTING					
RESTLESSNESS					
IMPULSIVITY					
NIGHTMARES					
DRUG USE					
ALCOHOL USE					
HOPELESSNESS					
EASILY DISTRACTED					
ELEVATED MOOD					
MOOD SWINGS					
OBSESSIVE THOUGHTS					
DISORGANIZED					
ANOREXIA					
GRIEF					
PHOBIAS					
HEADACHES					
WEIGHT CHANGES					
TRAUMA FLASHBACKS					
PANIC ATTACKS					
FEELING ANXIOUS					
FEELING PANICKY					
SUICIDAL THOUGHTS					
PAST SUICIDE ATTEMPTS					