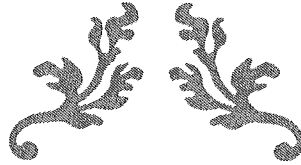
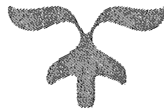


CONFIDENTIAL

Name: ____



Adolescent Inventory

Please read and answer the following questions. Information provided will be discussed during the initial meeting with the therapist.

Presenting Information

What are your primary concerns?

____

____

When did these concerns first start? ____

____

How have they or the family members been trying to cope/manage with these concerns?

____

____

What changes, stresses, or losses have occurred in the past 1-2 years?

____

____

____

Mental/Emotional Health History

Have they ever received counseling of any type? ___Yes ___No

Have they had services with this agency prior to this date? ___ Yes ___ No

Have they been hospitalized for mental health or drug/alcohol treatment? ___ Yes ___ No

If yes, please explain and provide dates:

____

Past providers and dates of services:

____

Has anyone in the family been diagnosed with mental health or emotional illness? ___ Yes ___ No

If yes, explain:

____

____

Symptoms Checklist

Please rate each symptom below using the scale provided. (No Concerns=0, 1, 2, 3, 4, 5= Major Concern)

Depressed __ Sleep Disturbance __ Anxiety/Agitation __ Obsessions __ Paranoia __

Suicidal Ideations ___ Substance Abuse __

Have they ever experienced thoughts of suicide? __Yes __No

In the past 2 weeks have they thought of suicide? __Yes __No

Have they ever attempted suicide? __Yes __ No

Medical History

Who is they Primary Care Doctor?

____

Place of Practice?

____

Do they take any medications? __ Yes __ No

Medication	Dosage:	Treating:

Please list any chronic illness, disabilities, medical conditions that they have been diagnosed with:

Illness/Disability	Dates:

Have they child ever experienced any type of abuse (physical, sexual, or emotional)? If yes, please explain.

____

____

Have they child ever made a statement of wanting to hurt him/herself or seriously hurt someone yes? If yes, please explain.

____

____

____

Have they child purposely hurt someone or him/herself? __Yes __No

If yes, please explain.

____

____

____

Have they child experienced any serious emotional losses (such as death of or physical separation from a parent or caretaker)? __Yes __No

If yes, please explain.

____

____

____

Please list any major life transitions or concerns.

____

____

____

Does your family have any current or history of court involvement with DHHS?

If yes, please explain. ____

____

____

Are there any concerns with the following?

Sleep	__Yes __No	Weight Gain/Loss	__Yes __No
Changes in eating habits	__Yes __No	Hearing Problems	__Yes __No
Vision Problems	__Yes __No	Speech Problems	__Yes __No

If they marked yes to any of the above, please explain: ____

____

Drug/Alcohol History

First Date of Use:	Last Date of Use:
Alcohol	
Uppers (Meth, Cocaine, Crack, etc.)	
Downers (Valium, Barbiturates, etc.)	
Marijuana	
Hallucinogens	
Inhalants	
Tobacco	
Other (please specify)	

If they checked yes on any of the above, please indicated the substance, frequency of use and duration of use. Do they feel as though they have abused the drugs listed above? If yes, explain.

____

____

Please list legal charges and dates:

____

____

Average number of hours they sleep at night? __________

How long does it take them to fall asleep? __________

Do they wake up during the night? __Yes __No

How would they rate they overall sleep at the present time?

Poor 1 2 3 4 5 7 8 9 10(excellent)

Social History

Do they have friends? __Yes __No

How many close friends do they have? 1 2 3 4 5 or more

List leisure/recreational activities:

___

___

___

List they strengths: ___

List they weaknesses: ___

Developmental History

Were they exposed to drugs or alcohol before birth or early childhood? If yes, please explain. ___

___

Are there any identified delays in development?

Speech Functioning __Yes __No Hearing Functioning __Yes __No

Visual Functioning __Yes __No Walking __Yes __No

Other Abilities __Yes __No

Have they had any serious injuries or accidents, specifically involving head injury? If yes, please explain. ___

___

Family History

Mothers Name: ______________________ Fathers Name: ______________________________

Occupation: ________________________ ________________________________

Name:	Age:	Relationship:	Grade/Job:

Who are you child's significant others NOT living in the same house?

Name:	Age:	Relationship:	Grade/Job:

Describe your child's relationship with their family siblings?

____

____

Who is your child closest to?

____

What are some strengths as a family?

____

____

Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets them in trouble? If yes, please explain.

____

____

____

Are there any behaviors that your child fails to do as often as you would like or when you would like?

____

____

____

How do you describe your child's self-esteem?

____

____

____

What goals would you like to accomplish during the therapy process as a parent?

____

____

____

Does your child have different goals they would like to accomplish? (If they are the same, you can skip this one.)

____

____

____

Is there anything else that you think would be important for me to know about your child or your family?

____

____

____