



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

<u>Medication</u>	<u>Dosage:</u>	<u>Treating:</u>

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

<u>Illness/Disability</u>	<u>Dates:</u>

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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.

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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?
