Francine Grevin, Psy.D.
1600 South Main Plaza, Suite 225
Walnut Creek, CA 94596
www.therapywalnutcreek.com

Licensed Clinical Psychologist PSY 16634
Telephone (925) 658-0030
Email: Dr.Grevin@eastbaypsychotherapyservices.com

TEEN QUESTIONNAIRE

This confidential questionnaire is designed to give me specific information about your past, your present, your primary issues or concerns, and other areas of interest. Although very personal in nature, the following questions will help me get to know you better. Please make every effort to answer each question to the best of your knowledge. I am happy to discuss any questions or concerns you may have about any of these items.

Personal History:

1. **NAME:**_____**AGE:**_____**D.O.B.**_____

2. **ADDRESS**_____

3. **TELEPHONE NUMBERS(S): CELL**_____**HOME**_____**MAY I LEAVE A MESSAGE AT EITHER?** _____

3. **PLACE OF BIRTH:** _____

4. **ETHNICITY:**
   _____

5. **RELIGIOUS/SPIRITUAL PREFERENCE:**
   _____

6. **HOW LONG HAVE YOU LIVED IN THIS AREA?:** _____

7. **WHERE DID YOU GROW UP?** _____

8. **WHAT IS YOUR SEXUAL ORIENTATION? (CIRCLE ALL THAT APPLY)**

Heterosexual **Gay** **Lesbian** **Bisexual** **Other**

9. **Are you currently sexually active?** _____

   Do you practice safe sex? _____

10. In your own words, please tell me what events led up to you coming here today:

_____

_____

_____

_____

11. Please rank your concerns/problems in the following areas on a scale of 1 to 10 (0 = No problems and 10 = Major problems). You may use the same number for more than one area.

Depression ----------

Anxiety/Worry ----------

Parents ----------

Friends ----------

School ----------

Substance Use ----------

Sex ----------

Legal ----------

12. What kinds of help do you think you need the most right now? __

_____
_____
_____
_____
_____
_____
_____
_____
_____

___

School Related:

1. Are you currently in school? _____

2. If "yes", which school are you attending?

3. What grade are you in? _____

4. Do you have a relationship with a teacher or counselor who you would feel comfortable talking to? _____

5. What is school like for you? __----------_____

6. What was your grade point average last report card? ----------

7. Are these grades better or worse than usual?_____

If your grades have changed, what do you think the change was related to?

_____

_____

8. Do you have a learning disability or learning problem? _____

If "yes", what is the disability? _____

Have you ever attended any special classes (i.e., resource program, gifted programs)?

_____

When did/do you attend the class?

_____

9. Have you ever been suspended or expelled from any school? _____

If "yes", please give details: _____

_____

10. During the past school year, about how many days were you absent when you were supposed to be in school? _____

11. Have you ever been in trouble at school related to an alcohol or other drug problem? _____

If "yes", please give details: ----------

Work History

1. **Current Job: ___---------- From_____ to_____**

   Employer: _____

3. **Previous Job:** _____ **From_____ to _____**

   Employer: _____

4. **Please rate your current level of satisfaction with your work:**

   Excellent Good Fair Poor

5. **Please rate the level of stress you experience in your current work situation:**

   Intense High Moderate Mild Little/None

Medical/Health History:

1. **Do you have, or have you ever had, a serious or chronic medical condition(s) (including past major surgeries?** _____

If yes, please provide date(s) and details: _____

_____

_____

2. **Have you had any serious accidents or injuries, head injury, loss of consciousness, history of seizures?** _

If yes, please provide date(s) and details: _____

_____

_____

Are you currently taking any medications (include "over the counter" and herbal)? _____

If yes, please list: _____

_____

3. ACOHOL AND DRUG USE:

a. Do you drink alcohol? _____ How often? (days per week): _____

Typical number of drinks per sitting? (# of drinks –> 1 drink = one 12 oz. beer, one 4 oz. glass of wine, or one shot (1 oz.) of hard alcohol) _____

Last Drink taken (Date and quantity): _____

Age when you first started drinking? _____

b. Do you use other drugs? _____

What kind(s)? _____

How much per sitting? _____

How often? _____

Last drug use (date and quantity): _____

c. Do you feel you have a problem with:

Alcohol? _____

Other Drugs? _____

If yes, please explain: _____

d. Previous treatment programs (please list dates, locations, and outcome): _____

_____

e. Has your drinking or drug use ever caused problems in your family or relationships? _____

f. Caused problems with your job? _____

g. Is it difficult for you to stop or control the amount you drink or use? _____

h. Have you ever been arrested for a D.U.I. or other drug related offense? _____

If yes, please give dates and disposition: _____

I. If you feel you have a problem with alcohol or drugs, would you like help? _____

4. Please check any symptoms that you currently experience, or have experienced, past or present:

SYMPTOM	CURRENT	PAST
Headaches		
Restlessness		
Dizziness		
Pain		
Excessive anger		
Less need for sleep		
Excess energy		
Elated mood		
Excessive spending		
Racing thoughts		
Feeling irritable		
Feeling Wired		
Mood Swings		
Grandiose thoughts		
Impulsive behavior		
Confusion		
Alcohol Craving		
Drug craving		
Eating problems		
Weight gain		
Weight loss		
Loss of appetite		

SYMPTOM	CURRENT	PAST
Difficulty getting to sleep		
Difficulty staying asleep		
Frequent nightmares		
Low energy		
Unable to have fun		
Decreased pleasure		
Feeling worthless		
Feeling hopeless		
Feeling isolated		
Suicidal thoughts		
Suicidal plans		
Attempted suicide		
Crying frequently		
Anxiety		
Frequent worrying		
Fears		
Panic attacks		
Avoiding places or situations due to fear or panic/anxiety		
Concentration problems		
Feel that others are plotting against you		
Constant suspicion or distrust		

SYMPTOMS	CURRENT	PAST
Hearing voices that others do not hear		
Seeing things others do not see		
Physical abuse		
Sexual abuse		
Emotional/verbal abuse		
Sexual problems		
Relationships problems		
Family conflict		
Fears of losing control		
Unwanted thoughts or behaviors		
Feeling the need to do/repeat things		
Obsessive/repetitive thoughts		
Unusual thoughts		
Strange experiences		
Thoughts of someone physically harming you		
Thoughts of physically harming someone		
Violent or aggressive behavior		

Psychiatric History:

1. **Have you ever participated in Counseling or Psychotherapy before?** _____

If "yes":

Type of Therapy (i.e., individual, family)?	With Whom?	Year?	Helpful?

2. **Have you ever taken any psychiatric medications?** _____

If "yes":

Type of Medication	Prescribed By Whom?	Year?	Helpful?

3. **Have you ever been hospitalized for psychiatric reasons?** _____

If "yes":

Reason for hospitalization?	Year?	Name of Hospital	Primary Doctor?	Helpful?

4. **Have you ever had serious thoughts of suicide?** _____

If "yes" please explain: ----------

5. **Have you ever had a plan to commit suicide?** _____

If "yes" please explain: ----------

_____

6. **Have you ever attempted to commit suicide?** _____

If "yes" please explain:

_____

_____

7. **Do you currently have thoughts or urges to hurt yourself or attempt suicide?** _____

8. **Have relatives /significant others had psychiatric symptoms or drug and alcohol problems in the past or currently? (e.g., Depression, Anxiety, OCD, Tics, Panic Disorder, Alcohol or Drug Abuse, Bipolar Disorder/Manic Depression, Schizophrenia, Learning or Developmental Disabilities, Suicide attempt or completion, Legal Problems, aggression, pedophilia, "nervous breakdown", psychiatric hospitalization…)**

Which Relative	Symptoms	Treatment	Psychiatric Medications/Hospitalizations

Legal History:

1. **Have you ever had any contacts with police/courts for any infraction greater than a speeding ticket?** ___

If "yes", please explain the circumstances _____

2. **Have you ever been arrested?** _____

If "yes", please explain the circumstances _____

_____

3. **Have you ever been convicted of a crime?** _____

If "yes", please explain the circumstances _____

_____

4. **Are you now or have you ever been on probation?** _____

If "yes", please explain the circumstances _____

_____

Family Information:

Please describe your relationship with the following people:

Father: _____

_____

Mother:
_____

_____

Brothers and Sisters:

_____

_____

_____

_____

Boyfriend or Girlfriend:

_____

_____

Important Friends:_____

_____

_____

_____