

INTAKE INFORMATION QUESTIONNAIRE FOR TEENAGERS

Client Name _____ Date: _____

Please answer the following questions. Use extra paper if necessary. Some of the questions may seem irrelevant to you, but I feel that a holistic view of you is very helpful to your total treatment. If a question offends you, simply skip it and discuss it with me later.

1. Are you in good physical condition? Yes No If not, what is wrong? _____

2. Do you take medications regularly? Yes No If yes, please list. _____

3. Are you having other forms of healthcare treatment? Yes No If yes, what? _____

4. What surgeries or hospitalizations have you had? _____

5. Are your parents alive? Yes No Are they healthy? Yes No

If they are not healthy, what illnesses do they have? _____

If they are not alive, what were the causes and dates of their deaths? _____

Please list the same for any brothers and/or sisters. _____

6. Do you place importance on what you eat and drink? Yes No

How is your appetite recently? _____

Please list some of the usual things you eat each day: _____

7. Do you take vitamins and/or minerals? Yes No If yes, what do you take? _____

8. Do you have any compulsive/addictive behaviors with which you struggle? Yes No
(I.e. Food, gambling, pornography, caffeine, nicotine, alcohol, or other legal or illegal drugs).
Please describe your use and the impact on your life. _____

9. School Performance:

a) Strengths: _____

b) Weaknesses: _____

10. Do you consider yourself a spiritual person? Yes No If so, how do you express and/or develop this? _____
11. Do you pray regularly? Yes No How is your faith relevant to you? _____
12. Do you attend a religious organization? Yes No If yes, please list all. _____
13. Do you attend or belong to other organizations? Yes No If yes, please list all. _____
14. Have you ever participated in the occult, séances, or use an Ouija board? Yes No If so, please explain. _____
15. Do you sleep well? Yes No How many hours do you sleep each night? _____
16. Do you rest or nap during the day? Yes No If yes, how and what kind of resting? (I.e. sleep, meditation, relaxation, etc.) _____
17. Do you exercise regularly? Yes No If yes, how often and what do you do? _____
18. Are you sexually active? Yes No If yes, how often? _____
19. Do you vacation regularly? Yes No When, where and with whom do you go? _____
20. What are your hobbies and interests? _____
21. Do you watch television regularly? Yes No What do you watch? _____
22. Do you read regularly? Yes No What do you read? _____
23. Do you listen to music regularly? Yes No What do you listen to? _____
24. Do you have a best friend? Yes No Do you have a close friend? Yes No
How long have you known this person? _____ How often do you see each other? _____
25. Do you see your family of origin often? Yes No If yes, how often? _____
If not, why not? _____
26. How much time do you spend online (computer, phone, etc.)
Facebook _____ Surfing _____
Communication _____ You Tube _____
Gaming _____
27. On a separate sheet of paper, please write a brief paragraph describing how you see yourself and your life at this time.

Thank you for taking the time to complete this questionnaire.