

**CONFIDENTIAL**

# **ASSESSMENT QUESTIONNAIRE - TEENAGERS**

**14-17 YEARS OLD**



*To the best of your ability, please answer all of the questions. All the information that you provide in this questionnaire will remain strictly confidential.*

Date: mm / dd / yy

Referral: \_\_\_\_\_

Person filling out this questionnaire: \_\_\_\_\_

## **Teenager Personal Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Sex:  Male  Female Birthdate: mm / dd / yy Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Mother Tongue: \_\_\_\_\_ Other Spoken Languages: \_\_\_\_\_

Mobile: ( ) \_\_\_\_\_ - \_\_\_\_\_

Other tel.: ( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_

I agree to receive periodical email correspondence from our clinic (i.e. appointment reminders and newsletters). Yes

# Parent Information

## Mother

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Tel.: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Tel.: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_

Mobile: ( ) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

## Father

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Tel.: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Tel.: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_

Mobile: ( ) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

## Parent Relationship

Your parents are:

Married       Separated      Mother: with new partner     Yes     No

Father: with new partner     Yes     No

# PRESENTING PROBLEMS

**In your opinion, what are the reasons you are consulting at this time?**

*Describe in as much detail as possible, including what exactly is the problem, who it involves, when it began, what else was going on in your life at that time, how frequently it occurs, what bothers you most about it etc...*

**What do you expect to get out of this therapy? What are your goals?**

## Stresses

**List the Top 3 stresses in your life right now.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

# Education/Work

Indicate your Level of Education. (select all that apply)

- Some high school. Grade: \_\_\_\_\_
- High School Diploma. Name of School: \_\_\_\_\_
- CEGEP diploma. Program: \_\_\_\_\_ Name of School: \_\_\_\_\_

Academic Standing: General average: \_\_\_\_\_

Subject strengths: \_\_\_\_\_

Subject weaknesses: \_\_\_\_\_

Are you part of a specialized plan of education for some or all your courses?  Yes  No

How many hours of homework do you do per day? \_\_\_\_\_

How often do you skip school?  Often  Sometimes  Never

Do you get along with your professors?  Yes  No

Do you get along with your peers?  Yes  No

Have you ever been bullied?  Yes  No **If yes, when and how? Please describe below.**

Do you work?  Yes  No

If so, where? \_\_\_\_\_ and how often? \_\_\_\_\_ hours/week

Do you do some volunteering?  Yes  No

If so, where? \_\_\_\_\_ and how often? \_\_\_\_\_ hours/week

# Medical History

Please list and explain any present or previous medical conditions.

Condition	Duration	Comments

	Yes	No	Comments
Have you ever had any kind of surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Please Specify Type and Dosage
Are you presently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you presently taking any supplements?	<input type="checkbox"/>	<input type="checkbox"/>	

# Psychological History and Mood State

Have you been to see a psychologist or psychiatrist before?      Yes       No

If yes, therapist's name \_\_\_\_\_

Reason for Consulting at the time \_\_\_\_\_

Does your family have a psychiatric history?      Yes       No

If yes, please specify: \_\_\_\_\_

Have you ever been physically or sexually abused?      Yes       No

If yes, please specify: \_\_\_\_\_

# Psychological/Behavioral/Relational Symptoms

Symptom	Yes	No	Comments
Social avoidance	<input type="checkbox"/>	<input type="checkbox"/>	
Anger/Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with authority	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble with concentration	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	
Agressive with others	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressive with yourself	<input type="checkbox"/>	<input type="checkbox"/>	
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	
Sadness	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of interest	<input type="checkbox"/>	<input type="checkbox"/>	
Fears (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Worry	<input type="checkbox"/>	<input type="checkbox"/>	
Obsessive or repetitive thoughts	<input type="checkbox"/>	<input type="checkbox"/>	

Insecurity	<input type="checkbox"/>	<input type="checkbox"/>	
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Others	<input type="checkbox"/>	<input type="checkbox"/>	

## Other Manifestations

Do you have any other troubles?

Symptoms	Yes	No	Comments
Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Sleeping Troubles	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

## Present Emotional Health

Using the scale below, where do you see yourself right now? (Please circle your response)

0      1      2      3      4      5      6      7      8      9      10

No Anxiety  
Relax and mellow  
most of the time

Moderate  
Anxiety  
Fully Functional

Very Panicky.  
Highly Anxious

0      1      2      3      4      5      6      7      8      9      10

Very Depressed  
Apathetic

Sad

Happy  
Joyful

Do you presently or have you ever considered committing suicide?  Yes  No

*If Yes, please specify*

# Medical Symptoms

Please indicate whether you currently have any of the following problems. If yes, describe how often.

<b>Musculoskeletal</b>		
<b>Muscle Pain</b>	No	Yes _____ When? _____ Where? _____
<b>Clumsy Walk</b>	No	Yes _____
<b>Poor Posture</b>	No	Yes _____
<b>Other Muscle Issues</b>	No	Yes _____
<b>Poor balance</b>	No	Yes _____

## Cardiovascular

<b>Shortness of Breath</b>	No	Yes _____
<b>Dizziness with Physical Exertion</b>	No	Yes _____
<b>Activity Limitation</b>	No	Yes _____
<b>Heart Murmur</b>	No	Yes _____



**Respiratory**

**Frequent Colds**      **No**      **Yes** \_\_\_\_\_

**Chronic Cough**      **No**      **Yes** \_\_\_\_\_

**Asthma**      **No**      **Yes** \_\_\_\_\_

**Hay Fever**      **No**      **Yes** \_\_\_\_\_

**Sinus Condition**      **No**      **Yes** \_\_\_\_\_

**Genitourinary**

**Urination in Pants/Bed**      **No**      **Yes** \_\_\_\_\_

**Pain while Urination**      **No**      **Yes** \_\_\_\_\_

**Excessive Urination**      **No**      **Yes** \_\_\_\_\_

**Strong odor to Urine**      **No**      **Yes** \_\_\_\_\_

**Gastrointestinal**

**Excessive Vomiting**      **No**      **Yes** \_\_\_\_\_

**Frequent Diarrhea**      **No**      **Yes** \_\_\_\_\_

**Constipation**      **No**      **Yes** \_\_\_\_\_

**Stomach Pain**      **No**      **Yes** \_\_\_\_\_

**Nausea**      **No**      **Yes** \_\_\_\_\_

**Skin**

**Frequent Rashes**      **No**      **Yes** \_\_\_\_\_

**Bruises Easily**      **No**      **Yes** \_\_\_\_\_

**Sores**      **No**      **Yes** \_\_\_\_\_

**Severe Acne**      **No**      **Yes** \_\_\_\_\_

**Itchy Skin (Eczema)**      **No**      **Yes** \_\_\_\_\_

**Blushes/turns red**      **No**      **Yes** \_\_\_\_\_

**Vision**

**Vision Problems**      No      Yes \_\_\_\_\_

**Wears Glasses**

**Or Contacts**              No      Yes \_\_\_\_\_

**Date of Most Recent Vision Exam** \_\_\_\_\_

**Allergies**

**Allergy to Medicine**    No      Yes      If yes, describe. \_\_\_\_\_

**Allergy to Food**              No      Yes      If yes, describe. \_\_\_\_\_

**Other Allergies**              No      Yes      If yes, describe. \_\_\_\_\_

**Hearing**

**Ear infections**              No      Yes \_\_\_\_\_

**Hearing Problems**      No      Yes \_\_\_\_\_

**Ear Tubes**                      No      Yes \_\_\_\_\_

**Date of Most Recent Hearing Exam** \_\_\_\_\_

**Speech**

**Stuttering**                      No      Yes \_\_\_\_\_

**Unclear Speech**              No      Yes \_\_\_\_\_

**Other Speech Issues**      No      Yes \_\_\_\_\_

**Date of Most Recent Speech Exam** \_\_\_\_\_

Women Only Section	Yes	No	Comments
At what age did you start menstruating? _____			
If you are menstruating, is your cycle: Regular? <input type="checkbox"/> Irregular? <input type="checkbox"/> Absent? <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>	<input type="checkbox"/>   <input type="checkbox"/>   <input type="checkbox"/>	
Before or during your period, do you experience Cramps? <input type="checkbox"/> Pain? <input type="checkbox"/> Migraines? <input type="checkbox"/> Irritability? <input type="checkbox"/> Weaknesses? <input type="checkbox"/> Depressed mood? <input type="checkbox"/>	<input type="checkbox"/>      <input type="checkbox"/>      <input type="checkbox"/>	<input type="checkbox"/>      <input type="checkbox"/>      <input type="checkbox"/>	
Have you ever gotten an abortion?	<input type="checkbox"/>	<input type="checkbox"/>	
How many pregnancies?  _____			
How many births?  _____			

# Diet

Describe a typical daily menu that you would eat.

Food	Yes	No	Approximately How Many Portions Per Day?
<b>Dairy</b> (i.e. Milk, Yogurt, Cheese, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Grains</b> (i.e. Bread, Cereal, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Vegetables</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Fruits</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Meat</b> (i.e. Beef, Chicken, Turkey, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Meat Alternatives</b> (i.e. Soy based products, tofu, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Fish</b> (i.e. Salmon, Tuna, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Caffeine</b> (i.e. Coffee, Tea, Supplements)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Other</b>	<input type="checkbox"/>	<input type="checkbox"/>	

# Exercise

Do you exercise regularly?  Yes  No

How often do you exercise per week? \_\_\_\_

Type of Exercise	Frequency	Comments

Which exercise do you enjoy the most? \_\_\_\_\_





**How long have you been together?** \_\_\_\_\_

**Number of sexual partners (now) :** \_\_\_\_\_ **Number of sexual partners (lifetime) :** \_\_\_\_\_

**Do you use a form of contraception?**  Yes  No      If yes, which one? \_\_\_\_\_

**How often do you use protection?**    Always     Sometimes     Never

With your partner...	Yes	No	Comments
Are you intimate?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you communicate well?	<input type="checkbox"/>	<input type="checkbox"/>	

**Describe your relationship with your romantic partner. Rate from 1 to 10:** \_\_\_\_\_

# Social

Do you consider yourself to have close friends?  Yes  No

How many? \_\_\_\_\_

List some social activities you engage in.

Social Activity	Frequency	Comments

What social activity do you enjoy the most? \_\_\_\_\_

# Hobbies/Interests/Activities

List some of your hobbies, interests and activities (e.g., sports, reading, painting, swimming).

Hobby/Interest/Activity	Frequency	Why do you enjoy this activity?

Do you play video games?  Yes  No

If so, how often? \_\_\_\_\_ hours per day

Watch TV?  Yes  No

If so, how often? \_\_\_\_\_ hours per day

Use social media (e.g., Facebook, Instagram, Snapchat)?  Yes  No

If so, how often? \_\_\_\_\_ hours per day



# Drugs and Alcohol Use

Do you smoke?

Yes  No

If yes, you smoke around \_\_\_\_\_ cigarettes/day

Do any of your friends drink alcohol or smoke cigarettes?  Yes  No

Do you drink?

Yes  No

If yes, you drink around \_\_\_\_\_ drinks/day

Do you use any illicit drugs (e.g., marijuana, cocaine, MDMA, LSD)  Yes  No

If yes, which one(s)? \_\_\_\_\_

You use drugs around \_\_\_\_\_/day

\_\_\_\_\_/week

## Other

Is there anything else you feel is important to share right now?

# CONSENT

In order to receive optimal care I understand that the health professionals at Sunflower Health Center use a multi-disciplinary team approach and may share pertinent information regarding my case with each other.

I authorize the sharing of information between the professionals of Sunflower Health Center.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I understand that the Practitioner involved in my case may need to communicate with other person(s) involved in my case (ex: physician, teacher, parent, other professionals etc.)

I authorize my Practitioner \_\_\_\_\_, to share pertinent information regarding my file specifically to:

1.

Name	Relationship	Address	Phone Number
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2.

Name	Relationship	Address	Phone Number
------	--------------	---------	--------------

3.

Name	Relationship	Address	Phone Number
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Signature: \_\_\_\_\_

Date: \_\_\_\_\_