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:_____

Mother tongue: _____ Other Spoken Languages: _____

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: new couple life □ Yes □ No

Father: new couple life □ 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?	▫	▫	
Do you have any allergies?	▫	▫	

	Yes	No	Please Specify Type and Dosage
Are you presently taking any medications?	☐	☐	
Are you presently taking any supplements?	☐	☐	

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

Symptoms	Yes	No	Comments
Social avoidance	☐	☐	
Anger/Tantrums	☐	☐	
Hyperactivity	☐	☐	
Problems with authority	☐	☐	
Trouble with concentration	☐	☐	
Sleep Disturbances	☐	☐	
Agressive with others	☐	☐	
Aggressive with yourself	☐	☐	
Mood swings	☐	☐	
Irritability	☐	☐	
Sadness	☐	☐	
Loss of interest	☐	☐	
Fears (specify)	☐	☐	
Worry	☐	☐	
Obsessive or repetitive thoughts	☐	☐	

Insecurity	☐	☐	
Agitation	☐	☐	
Anxiety	☐	☐	
Others	☐	☐	

Other Manifestations

Do you have any other troubles?

Symptoms	Yes	No	Comments
Memory Problems	☐	☐	
Headaches/Migraines	☐	☐	
Fatigue	☐	☐	
Sleeping Troubles	☐	☐	
Eating Disorders	☐	☐	
Other	☐	☐	

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.

Musculoskeletal

Muscle Pain **No** **Yes** _____

When? _____ **Where?** _____

Clumsy Walk **No** **Yes** _____

Poor Posture **No** **Yes** _____

Other Muscle Issues **No** **Yes** _____

Poor balance **No** **Yes** _____

Cardiovascular

Shortness of Breath **No** **Yes** _____

Dizziness with Physical Exertion **No** **Yes** _____

Activity Limitation **No** **Yes** _____

Heart Murmur **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** _____

Gastrointestinal

Excessive Vomiting	**No**	**Yes** _____
Frequent Diarrhea	**No**	**Yes** _____
Constipation	**No**	**Yes** _____
Stomach Pain	**No**	**Yes** _____
Nausea	**No**	**Yes** _____

Excessive Urination	**No**	**Yes** _____
Strong odor to Urine	**No**	**Yes** _____

Skin

Frequent Rashes	**No**	**Yes** _____
Bruises Easily	**No**	**Yes** _____
Sores	**No**	**Yes If yes, describe.** _____
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 menstruated, is your cycle: Regular? Irregular? Absent?	 ☐ ☐ ☐	 ☐ ☐ ☐	
Before your period, do you experience Cramps? Pain? Migraines? Irritability? Weaknesses? Depressed mood?	 ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐	
Abortions?	☐	☐	
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?
Dairy (i.e. Milk, Yogurt, Cheese, etc…)	☐	☐	
Grains (i.e. Bread, Cereal, etc...)	☐	☐	
Vegetables	☐	☐	
Fruits	☐	☐	
Meat (i.e. Beef, Chicken, Turkey, etc…)	☐	☐	
Meat Alternatives (i.e. Soy based products, tofu, etc…)	☐	☐	
Fish (i.e. Salmon, Tuna, etc…)	☐	☐	
Caffeine (i.e. Coffee, Tea, Supplements)	☐	☐	
Other	☐	☐	

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? _____

Sleep

How many hours do you sleep per night? _____ **What time do you usually go to bed? _____**

Do you have difficulty sleeping? ☐ Yes ☐ No **Do you have difficulty waking up?** ☐ Yes ☐ No

If so, what is the difficulty: ☐ Falling asleep ☐ Nightmares

☐ Waking up throughout the night ☐ Early Wake Up

☐ No sleep at all

☐ Other Specify: _____

Do you feel rested upon waking? ☐ Yes ☐ No

Life Events

Think of a few life events that had a significant effect on you. (From now to childhood).

Event	Age	Effect on you

Family History

Are you closer to one parent than the other? **□ No** **□ Yes** **If yes, which? _____**

Have you ever experienced any parental separations, divorces, or death? **□ No** **□ Yes**

If yes, when? _____ How old were you at this time? _____

Please describe the circumstances._____

_____

If parents are separated or divorced, who has custody of the child? _____

How often do you see the other parent? (Check one)

□ **Weekly or More Often** □ **Once or Twice a Month** □ **Few Times a Year** □ **Never**

Using the scale below, how do you consider your family relationships? (Please circle your response)

0 1 2 3 4 5 6 7 8 9 10

Poor Good Completely Satisfying

Describe your relationship with your mother. Rate from 0 to 10: ____

Describe your relationship with your father. Rate from 0 to 10: _____

Describe your relationship with your siblings (if applicable).

Name	Age	Rate 1 to 10	Quality

Do you have your own room? □ **Yes** □ **No**

How do you find the rules at home? □ **Very strict** □ **Sometimes strict** □ **Not strict**

Relationships

Do you have a romantic partner? ☐ Yes ☐ No Name:_____

How long have you been together? _____

Number of sexual partners: ____

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?	☐	☐	
Are you sexually active?	☐	☐	
Do you communicate well?	☐	☐	
Did you ever get tested for a sexually transmitted disease or a pap smear?	☐	☐	

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

2.

Name Relationship Address Phone Number

3.

Name Relationship Address Phone Number

Signature:_____ **Date: _____**