Abiding Hope Adolescent Questionnaire

Identity Information

Name:

Preferred Name:

Sex: M or F

Boyfriend or Girlfriend: Y or N Name?

Race:

Attend School? Y or N Grade level: School Name:

Do you have a job? Y or N Work location:

Referral Source:

Any person authorized to receive information?

Consent Form Signed for the above person?

Disclosure Statement Signed? Y or N

Emergency Contact?

Consent signed?

Problem:

Before we start, what do you hope to gain from counseling?

How long have you been having these behaviors/challenges?

How do you feel today?

How do you usually feel day to day?

Current or past stressors within your family?

Anything that makes these stressors better?

Makes it worse?

When did you first notice them?

Do the challenges/issues/problems prevent you from doing anything in activities of daily living (ADL's)?

Perceived Strengths?

Perceived Weaknesses?

Social Issues/Interactions with others?

Describe a typical day before this current problem?

What have you already done to address this concern and how effective were these efforts?

Was there an event that caused you to seek treatment now? ____ If yes, please describe.

Treatment/Medical History

Current medical issues?

If yes, then when were you diagnosed?

Any hospitalizations or surgeries? When?

Current medications?

Drug allergies?

Female and age appropriate specific:

Childbirths?
Miscarriages?
Abortions?
Complications?

Mental Illness Present and Past:

Any family history of therapy?

Any family history of mental illness?

Do you have any previous diagnosis?

Have you been in counseling before? What helped? What didn't?

Difficulty sleeping? Y or N If yes, please explain:

Average hours of sleep each night?

Sleep pattern before current symptom?

Do you feel rested? Y or N

Highlight or circle the ones that apply:

Loss of interest Withdrawal Depressed Mood Anxiety Guilt

Issues leaving home Fear(s) Anger Panic Avoidance Patterns

Irritability Worthlessness Hopelessness Helplessness Crying

Racing Thoughts Vigilance Increase/Decrease in Energy Tension

Sexuality

Please list any questions, concerns, or comments you have, if any, about your gender or gender identity (sense of your femaleness/maleness).

Are you sexually active?

Do you use protection?

Are you currently using birth control? Yes or No

If YES: Which type are you using: ___Pills ___IUD ___Condoms ___Foam ___Foam & Condoms

___Patch ___Diaphragm ___Ring ___Depo ___Tubal Ligation ___Vasectomy

Other:

Do you have a primary (main) sexual partner? Yes or No

Do you have any casual sexual partners? Yes or No

Have you been tested for sexually transmitted diseases?

Dietary Issues

Unsual dietary habits: Y or N Changes in diet habits since problem developed?

Weight Loss or Gain? Trying to loose weight? Y or N Anorexia? Y or N

Bulimia? Y or N

Hallucinations:

Have you ever seen things that others are not seeing or heard anything that others are not hearing? Y or N

Have you ever heard voices telling you to do certain things? Y or N

Felt sensations that others don't have? Y or N

If yes, what do you do when you hear the voices/see things?

How long?

Developmental:

Any developmental issues (trouble walking, talking, early childhood milestones)?

Do you remember a time that you did not understand instructions at school or from medical professionals?

What type of grades do you usually get? A's B's etc..?

Are you able to concentrate in school?

Have you had issues with your teachers? Y or N

Have you had issues with other students? Y or N

Substance Use/Abuse

Any current or previous drug use/caffeine/alcohol use? Y or N
If yes, what was used exactly and how much?

Age of first use:

If yes to the first question, when do you use drugs/alcohol the most?

When is the last time you took drugs or alcohol?

How much each day?
Each week?
Each month?

Family history of drugs/alcohol/caffeine use?

By whom and what?

Have you ever been told you should stop using any substance?

If yes, by whom?

Why do you think they told you to stop?

Risk Assessment

Any history of abuse? Y or N By Whom?

What kind of abuse? (emotional/neglect, sexual, physical etc.?)

For how long?

Any thoughts of suicide, self-harm (such as cutting), or a plan to hurt someone else?

Plan to make sure that you no longer are dealing with the pain?

Any attempts of suicide?

What has prevented you from attempting or completing suicide thus far?

Any friends/family members that know about what you are going through right now?

How often do you talk with them or discuss your current challenges?

Electronic Use

How much time is spent watching television/playing videogames/using the computer daily?

How much time do you spend on your phone each day? Add up all the times you are on your phone for each day.

Do you feel you are on your phone/electronic device too much?

Family/Social

Where is your family from?

Who did you grow up with? (blended/foster/single parent/both parents)

Where did you grow up?

# of brothers/ # of sisters?

Do you feel close to your parents/caregivers?

How would your family describe you at home?

Do you have a supportive social network of friends?

If yes, what are your closest friends' names?

FAMILY CONCERNS (Please circle or highlight any family concerns that your family is currently experiencing):

Fighting Disagreeing about relatives Feeling distant Disagreeing about friends

Loss of fun Alcohol use Lack of honesty Drug use Physical fights

Infidelity (parents) Education problems Divorce/separation Financial problems Issues regarding remarriage Death of a family member Birth of a sibling

Abuse/neglect Birth of a child Job change or job dissatisfaction

Inadequate housing/feeling unsafe Inadequate health insurance

Other concerns not listed above?

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.

2. Are you happy with the amount of friends you have? (Y/N)

3. Have you ever been bullied? (Y/N)

4. Are your parents happy with your friends? (Y/N

5. Are you involved in any organized social activities (e.g. sports, scouts, music)?

Faith Background/Denomination:

Regarding spirituality or religion, how have you been raised?

How satisfied are you in how you have been religiously brought up so far?

What are your current religious beliefs?

How do you practice your faith?

Risk Taking/Impulsive Behavior (current/past)

Do you engage in any of the following behaviors? Circle or Highlight

Unprotected Sex **Gang Involvement** **Shoplifting** **Reckless Driving**

Drug Dealing **Carrying/using weapon** **Other:**

Satisfaction with Life Scale:

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

- 31 - 35 Extremely satisfied
- 26 - 30 Satisfied
- 21 - 25 Slightly satisfied
- 20 Neutral
- 15 - 19 Slightly dissatisfied
- 10 - 14 Dissatisfied
- 5 - 9 Extremely dissatisfied

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, *49*, 71-75.