Youth Mental Health History (ages 12-17)

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Purpose of this Questionnaire:
The purpose of this lengthy questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and as accurately as you can, you will enhance your therapeutic program. The highly personal information received in this written evaluation and in your individual sessions is strictly confidential as outlined in your copy of the Colorado State Mandatory Counselor Disclosure.

If you do not desire to answer a particular question, write "non-applicable or NA."

CLIENT INFORMATION

Name:_____Date of Birth_____
Phone Number_____Is it okay to leave a message Yes___No___
Religious Preference_____

Have you previously been in counseling before? Yes____ No____
If Yes, what did you find **most helpful?**_____
_____
If Yes, what did you find **least helpful?**_____
_____
How long did you go to therapy?_____With Whom?_____
For what purpose?_____

Current medications or herbs used:

Name	Miligrams	Purpose

CURRENT REASON FOR SEEKING COUNSELING

Please provide a brief description of the reason(s) you are seeking counseling today?
_____
_____

What would you like to see happen as a result of counseling?
_____
_____

On the scale below please check the severity of your problem(s):

___mildly upsetting
___moderately severe
___very severe
___extremely severe
___totally incapacitating

PERSONAL STRENGHTS

What activities do you enjoy and feel you are successful at when you do them?_____
_____
Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? Please describe._____

FAMILY & PEERS

List all the people with whom you currently live:

NAME SEX AGE RELATIONSHIP TO YOU

_____
_____
_____
_____
_____
_____

Are your parents married or divorced?_____
Do you think their relationship is good? _____Yes _____No _____Unsure
If your parents are divorced, whom do you primarily live with?_____
Do you get along with the people you live with? _____Yes _____No

SCHOOL & ACTIVITIES

What school do you go to?_____What Grade/year_____
Are you having a hard time with kids at school or other peers or friends ____Yes _____ No
Are you happy with the amount of friends you have? _____Yes _____No
Have you ever been bullied? _____Yes _____No
Do you feel safe at school? _____Yes _____No
Are your parents happy with your friends? _____Yes _____No
Are you involved in any organized social activities (e.g. sports, scouts, music)? _____Yes _____No
Do you have at least one trusted friend you can talk to about any problems you may have? ___Yes ____No
Do you have at least one caring adult you feel comfortable talking to? _____Yes _____No
How do you consider yourself socially:_____outgoing _____shy _____depends on the situation.
Have you ever been physically or sexually abused by anyone (hit, kicked, pushed, forced or tricked into having sex, or touched in a way that made you uncomfortable)? _____Yes _____No

Do you have a job?_____Yes_____ No_____
What is it?_____How many hours per week?_____
What sport, activities or hobbies do you do?_____
_____

How many hours of screen time (smartphone, TV, computer games, etc) do you spend most days?
_____<2 hours _____2-4 hours _____5-8 hours _____>8 hour

Do you get at least 30 minutes of exercise at least 3 times a week? _____Yes _____No
How much sleep do you typically get each night?_____
How long does it take you to fall asleep?_____
Do you have nightmare?_____

CHEMICAL USE AND HISTORY

Have you ever used tobacco (Juul, vape, smoke, chew?) _____Yes _____No
Does anyone you live with smoke or chew or Vape? _____Yes _____No
Have you ever tried beer, wine or other alcohol? _____Yes _____No
Have you ever used drugs like marijuana, cocaine, speed, fentanyl? _____Yes _____No
Does anyone in your family drink alcohol or use drugs so much that it worries you? _____Yes _____No

HEALTH ISSUES: Check all that apply

__headaches	__dizziness	__fainting spells
__palpitations	__stomach hurts	__anxiety
__diarrhea	__fatigue	__no appetite
__anger	__mean to others	__insomnia
__nightmares	__stubborn	__alcoholism
__feel tense	__eating problems	__shaking
__depressed	__suicidal thoughts	__take drugs
__unable to relax	__fearful	__allergies
__don't like weekends	__over ambitious	__shy with people
and vacations	__self-mutilatin	__concentration difficulties
__excessive sweating	__inferiority feelings	__can't make decisions
__can't keep a job	__memory problems	__home conditions bad
__financial problems	__lonely	__unable to have a good time

Words you use to describe yourself: Check all that apply

__worthless	__useless	__a "nobody"	__"life is empty"	__confident
__inadequate	__stupid	__incompetent	__naïve	__can't do anything right"
__guilty	__evil	__full of hate	__horrible thoughts	__hostile
__anxious	__agitated	__cowardly	__unassertive	__aggressive
__ugly	__deformed	__unattractive	__repulsive	__considerate
__unloved	__misunderstood	__bored	__restless	
__confused	__unconfident	__in conflict	__full of regrets	
__worthwhile	__sympathetic	__intelligent	__attractive	

SEXUALITY

When and how did you obtain your first knowledge of sex?_____
Are you comfortable with your current sexual orientation? _____Yes _____No
Are you attracted to: _____Males _____Females _____Both _____Not Sure
Are you, or do you wonder if you are gay, lesbian, bisexual or transgender? _____Yes _____No
Are you currently dating or going out with someone? _____Yes _____No
Have you ever have sex? _____Yes _____No
If yes, are/were your partners _____Male _____Female _____Both
If you have sex, how often do you use a condom? ___Always ____Sometimes ___Never
Do you have any concerns with your past sexual experiences? _____Yes _____No
Have you, or are you experiencing any issues related to your age, gender or race? _____Yes _____No

SENTENCE COMPLETION (Please complete the following):

1. I like _____

2. I am_____

3. My teachers_____

4. I hardly ever_____

5. The saddest thing is_____

6. Fathers_____

7. I hate_____

8. I would like to_____

9. One of the ways people hurt me is_____

10. I hope that I never_____

11. I often daydream about_____

12. Mothers_____

13. Three wishes1._____2._____3._____

14. If I weren't afraid to be myself, I might_____

15. One of the things I'm angry about is_____

16. Boys _____

17. I get help from_____

18. I need to change_____

19. I get mad when_____

20. My biggest problem is _____

21. I nearly always feel _____

22. Dating_____

23. My future _____

24. Sisters_____

25. I secretly _____

26. I failed _____

27. Most students think I _____

28. I am scared when _____

29. What annoys me _____

30. I worry about _____

31. Girls _____

32. I remember _____

33. A job I would like is _____because_____

34. I look up to _____

35. Most adults are _____

36. A job I would hate is _____because_____

37. Brothers_____

38. Students at my school_____

39. My thoughts_____

40. I get frustrated when _____

41. When I was younger _____

42. I regret _____

43. The happiest thing is _____

10. Additional Information

A. What else would you like your therapist to know about you now?

Thank you for taking the time to complete this questionnaire.