



Patient Name: \_\_\_\_\_

**ADOLESCENT SYMPTOM CHECKLIST**

The following is a list of symptoms that have to do with various psychological problems that children or adolescents may experience. Please circle the number from zero (0) to four (4) that best describes how much this symptom or problem bothers you. Use the following scale:

**0 = Not at all    1 = A little bit    2 = Moderately    3 = Quite a bit    4 = Extremely**

<b>In the past week, how much were you bothered by:</b>	Not at all	Moderately	Extremely	Extremely
1. Feeling depressed or discouraged	0	1	2	3 4
2. Feeling easily annoyed or irritated	0	1	2	3 4
3. Feeling little interest in things or avoiding enjoyable activities, family or friends	0	1	2	3 4
4. Feeling unemotional or without feeling	0	1	2	3 4
5. Having difficulty making or keeping friends	0	1	2	3 4
6. Frequently refusing to attend or missing school/work	0	1	2	3 4
7. Feeling worthless or hopeless about the future	0	1	2	3 4
8. Refusing to eat (no appetite) or eating excessively	0	1	2	3 4
9. Having difficulty sleeping or appears tired/sleepy during the day	0	1	2	3 4
10. Thoughts of suicide: thinking "I wish I were dead," "life isn't worth living anymore"	0	1	2	3 4
11. Suicide attempt: intent or action to hurt or kill self with pills, weapons, cuts, etc.	0	1	2	3 4
12. Racing thoughts, rapid speech or feeling overly high in mood	0	1	2	3 4
13. Being easily distracted or trouble concentrating, can't stay focused on activities	0	1	2	3 4
14. Feeling so restless you can't sit still	0	1	2	3 4
15. Failing to finish things that you have started	0	1	2	3 4
16. Acting without thinking (impulsively)	0	1	2	3 4
17. Difficulty paying attention	0	1	2	3 4
18. Feeling anxious: worrying excessively or worrying about many things	0	1	2	3 4
19. Feeling unreasonable fear of strangers	0	1	2	3 4
20. Expressing negative or critical things about yourself	0	1	2	3 4
21. Experiencing physical problems such as headaches, nausea, dizziness etc.	0	1	2	3 4
22. Having to avoid certain things, places or activities because they frighten you	0	1	2	3 4
23. Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2	3 4
24. Urinating or having bowel movements in a place other than the toilet	0	1	2	3 4
25. Believing that others know what you are thinking	0	1	2	3 4
26. Recurrent thoughts, impulses, or images that are intrusive and troubling	0	1	2	3 4
27. Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc.)	0	1	2	3 4
28. Feeling that you are watched or talked about by others	0	1	2	3 4
29. Seeing or hearing things outside yourself that others tell you are not really there	0	1	2	3 4
30. Repeatedly make odd movements or strange facial expressions	0	1	2	3 4
31. Mumbling, making unusual vocal noises or speaking in a disorganized way that does not make sense	0	1	2	3 4
32. Lying, cheating, or stealing	0	1	2	3 4

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33. Expressing considerable and sustained interest in sexual activities	0	1	2	3	4
34. Expressing a lack of fear of getting hurt in dangerous activities	0	1	2	3	4
35. Expressing an interest in violence, death, accidents etc.	0	1	2	3	4
37. Hurting, pushing or physically threatening others	0	1	2	3	4
38. Having urges to break or smash things	0	1	2	3	4
39. Getting into frequent arguments with family members or teachers	0	1	2	3	4
40. Educational concerns such as poor academic performance or poor conduct in school	0	1	2	3	4
41. Other:	0	1	2	3	4

For the next several questions, please circle the number that represents how frequently you use any of the following substances. Use the following scale:

**0 = Never    1 = In past, not currently    2 = Monthly    3 = Weekly    4 = Almost daily**

	Never	In Past	Monthly	Weekly	Daily
a.Caffeine: coffee, caffeinated beverages	0	1	2	3	4
b.Nicotine: cigarettes, cigars	0	1	2	3	4
c.Beer / Liquor	0	1	2	3	4
d.Marijuana, hash	0	1	2	3	4
e.Sedatives: tranquilizers, sleeping pills, barbiturates, valium, xanax, Quaaludes	0	1	2	3	4
f.Inhalents / Solvents: glue, toluene, gasoline	0	1	2	3	4
g.Stimulants: amphetamines, "speed", Ritalin	0	1	2	3	4
h.LSD, psychedelics, mescaline, peyote, DMT, ecstasy	0	1	2	3	4
i.Cocaine / Crack / Crank, coca leaves	0	1	2	3	4
j.Opioids: herion, codeine, Demerol, morphine, percodan, methadone, darvon, oxycodone	0	1	2	3	4
k.PCP, "angel dust", ketamine	0	1	2	3	4
l.Other:	0	1	2	3	4

**PSYCHOLOGICAL HISTORY**

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? Yes    No  
 If yes, what and when: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been in counseling or psychotherapy before? Yes    No  
 If yes, where and when: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had any past hospitalizations for emotional problems? Yes    No  
 If yes, when and where: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever intentionally hurt yourself or made a suicide attempt? Yes    No  
 If yes, explain how and when: \_\_\_\_\_  
 \_\_\_\_\_

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### MEDICAL HISTORY

Check if you are currently experiencing or have ever experienced:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Head injury                       | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Asthma or hay fever              |
| <input type="checkbox"/> Heart (trouble, disease, surgery) | <input type="checkbox"/> Thyroid problem            | <input type="checkbox"/> Sinus problems                   |
| <input type="checkbox"/> Heart murmur                      | <input type="checkbox"/> Kidney or bladder problems | <input type="checkbox"/> Weight change/change in appetite |
| <input type="checkbox"/> Heart pacemaker                   | <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Glaucoma/Cataracts               |
| <input type="checkbox"/> Rheumatic fever or heart disease  | <input type="checkbox"/> Jaundice/rashes/sores      | <input type="checkbox"/> Neurological disorders           |
| <input type="checkbox"/> Abnormal blood pressure           | <input type="checkbox"/> Hepatitis – type A B C     | <input type="checkbox"/> Memory loss                      |
| <input type="checkbox"/> Ulcers/abdominal pain             | <input type="checkbox"/> Arthritis / Rheumatism     | <input type="checkbox"/> Venereal disease                 |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> HIV positive / AIDS / ARC        |
| <input type="checkbox"/> Epilepsy (Seizure Disorder)       | <input type="checkbox"/> Hemophilia/blood disease   | <input type="checkbox"/> Hearing impaired                 |
| <input type="checkbox"/> Tuberculosis or lung disease      | <input type="checkbox"/> Sickle Cell disease        | <input type="checkbox"/> Visual problems                  |
| <input type="checkbox"/> Emphysema                         | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Broken bones                     |
| <input type="checkbox"/> Cancer / tumors                   | <input type="checkbox"/> Fainting spells            | <input type="checkbox"/> Other _____                      |

If you checked any of the above medical items, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of primary care Physician: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Psychiatrist: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Are you currently experiencing any physical pain?

Yes No

If yes, where is the pain: \_\_\_\_\_

Are you currently receiving care for your pain?

Yes No

By whom: \_\_\_\_\_

Do you have any allergies or reactions to medication?

Yes No

If yes, what medications: \_\_\_\_\_

Are you taking any prescribed medications?

Yes No

Name of medication	Dosage and Frequency	Reason	Physician

Please indicate any herbal or homeopathic substances that you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**FAMILY HISTORY**

Please list Parents, Siblings, Spouse/Partner, Children, and Significant Relatives/Others:

Name (First & Last)	Relationship	Age	School / Occupation	City of Residence

How many pregnancies have you experienced? \_\_\_\_\_

Where were you born? \_\_\_\_\_

Who currently lives in your household? \_\_\_\_\_

Is there a history of depression, anxiety, alcoholism, or other mental health conditions in your family?      Yes      No  
If yes, who? What was the problem? Did they receive treatment or medication? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever experienced any emotional, physical, or sexual abuse?      Yes      No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been accused of assaulting or inappropriately touching someone?      Yes      No  
If yes, please explain who / when: \_\_\_\_\_  
\_\_\_\_\_

Does the use of alcohol or drugs by someone close to you contribute to your problems?      Yes      No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you grow up in a home in which a parent abused alcohol or drugs?      Yes      No

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**EDUCATIONAL & VOCATIONAL HISTORY**

What grade are you currently in? \_\_\_\_\_ Name of school: \_\_\_\_\_

Who is the contact person (principle or counselor) at your school? \_\_\_\_\_

How are you doing academically in school? \_\_\_\_\_

How is your conduct in school? \_\_\_\_\_

Are you in any special classes in school (speech, LD, ED, accelerated)? YES or NO  
If YES, please explain:

What extracurricular activities are you involved in? \_\_\_\_\_

Have your relationships with your friends changed recently? \_\_\_\_\_

What hobbies or interests do you have? \_\_\_\_\_

Do you work or have a job? If yes, list job/title: \_\_\_\_\_

How many hours per week? \_\_\_\_\_

Have you ever been fired? YES or NO If yes, explain: \_\_\_\_\_

Do you have any language or reading difficulties? YES or NO If yes, explain: \_\_\_\_\_

**LEGAL HISTORY**

Do you have a legal history consisting of past or current:

Arrests Yes No Explain: \_\_\_\_\_

Misdemeanor Charges Yes No Explain: \_\_\_\_\_

Criminal Charges Yes No Explain: \_\_\_\_\_

Legal Guardianship/Protective Placement: \_\_\_\_\_

Probation Yes No Explain/Name of PO: \_\_\_\_\_

**CULTURAL / RELIGIOUS / SPIRITUAL HISTORY**

What is your ethnic or cultural heritage? \_\_\_\_\_

In what religion did you grow up? \_\_\_\_\_ Your current religion? \_\_\_\_\_

How does your ethnicity or religious beliefs influence your life? \_\_\_\_\_

Signature of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_