



**soul &
psyche**
COUNSELING
SERVICES, LLC

Adolescent

QUESTIONNAIRE FOR NEW CLIENTS

Patient Name: _____

Date: _____

How many sessions are you expecting to need? 1-10 10-20 ongoing

What are your primary challenges that bring you to therapy?

What are you hoping to gain from therapy?

Check any of the following abuses your child/dependent has experienced in the past or is currently experiencing: *Physical* *Emotional* *Verbal* *Sexual* *Witness of Abuse* *Neglect*

List any current medical conditions/illnesses:

List any current medications: *(or attach list)*

Name	Dose	Frequency	Reason	Physician

List any past mental health or psychiatric history/treatment (i.e., past therapy, issues of self-harm or suicide attempts, use of medications, diagnoses):

List family history of mental health or psychiatric issues involving parents, siblings, grandparents, aunts/uncles (i.e., depression, anxiety, bipolar, suicide attempts):

Describe your child/dependent's strengths and weaknesses:

Name of person completing form: _____

Parents: Please check any symptoms or experiences that you have observed in the last month.

(A second copy of this checklist is included for older children who may wish to report their own observations as well)

Nightmares		Persistent, repetitive, intrusive thoughts, impulses or images
Traumatic experience		
Easily startled, feeling 'jumpy'		Rapid mood changes
Intrusive memories		Racing thoughts
Panic attacks		Risky behaviors
Fear of certain objects or situations (i.e., flying, heights, bugs, etc.)		Binge eating
		Voluntary vomiting
Feeling numb		Excessive exercise
Feeling confused as to what is real and unreal		Lying
Repetitive sounds or body movements (i.e., rocking, vocal sounds)		Manipulation of others to fulfill desires
		Tantrums/angry outbursts
Repetitive behaviors or mental acts (i.e., counting, checking locks, washing hands)		Acts or threats of violence toward people/animals
Fixations/Obsessions		Acts of violence toward objects
Avoiding people, places, activities, or specific things		Unusual sexual behaviors
		Concerns about sexuality or gender identity
Difficulty making friends		Other:
Difficulty leaving home		
Sensory sensitivity		

Name of person completing form: _____

Please check any symptoms or experiences that you have observed in the last month.

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	Difficulty leaving home		
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