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### Adolescent Initial Evaluation Questionnaire

Today's Date: \_\_\_\_\_

#### Section 1: Personal Information

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Work Telephone: \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Cell phone: \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Email: \_\_\_\_\_ May I email you? \_\_\_\_\_

How did you learn about or get referred to my practice? \_\_\_\_\_

Emergency Contact Person (and responsible person if you are under 18 years old):

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

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Their home phone number: \_\_\_\_\_

Their work phone number: \_\_\_\_\_

Their cell phone number or pager: \_\_\_\_\_

Please let me know if any of the above information changes (address, phone, email, etc.).

**Section 2: Employment/School Information**

Name of employer or school (if applicable): \_\_\_\_\_

If in school, do you also have a job? \_\_\_\_\_

What kinds jobs have you held in the past (in chronological order)?

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

If you are in school, what are you hoping to do upon graduation?

\_\_\_\_\_

**Section 3: Family Information**

Please note any immediate family members (spouse/partner, children, siblings, parents, relatives, etc.) using the categories below:

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Age if living OR year of death: \_\_\_\_\_ Where do they live? \_\_\_\_\_

Please describe your father's personality and his attitude toward you (past and present):

Please describe your mother's personality and her attitude toward you (past and present):

Please describe your relationship with your siblings (past and present):

In what ways were you punished by your parents/guardians as a child?

Describe the atmosphere of your home. How did your parents get along with each other? With you and your siblings?

If you are not being brought up by your parents, who is bringing you up and when did this begin?

Have any close relatives had marital difficulties or been divorced? If so, who, and do you know what the issues were?

What deaths, losses (including miscarriages), or separations have you experienced in your family? What were your feelings and how did you cope with them?

Is there anyone else living in your home that you have not listed above?

Do you live in a house, apartment, etc.?

#### **4. Relationship Information**

If you are presently in a relationship, how long have you been in this relationship?

On a scale of 1-10 (if 1 = not at all satisfied, 10= extremely satisfied), how would you rate your current relationship in terms of satisfaction?

How could you move that number up a number or two?

Please describe your relationship with your partner. Your attitudes toward each other, how you handle conflict, etc.

If you are not in a relationship and have been before, please describe your relationship history (name of person/people, how long dated, when relationship ended, etc.)

In terms of sexual orientation, how do you identify?

- Heterosexual       Homosexual (Gay/Lesbian)       Bisexual       Questioning  
 Other \_\_\_\_\_       Prefer not to answer

Is this problematic for you at all?

If you are not in a relationship and have not been in one as of yet, how important is it to you to be in a relationship? What do you hope for in the future in terms of a relationship?

## **Section 5: Current and Past Problems**

### **Current Problems**

Please describe the key problems for which you are currently seeking treatment. Please discuss when it started, length of time, any specifics you consider important, why you are coming now, etc. Feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

Are there any other environmental factors that contribute to your difficulties (e.g., financial difficulties)?

What other personal problems have you had?

Do you have some idea how these problems developed?

### **Section 6: Your Social Environment**

Who are the most emotionally supportive people in your life?

How would you describe your friendship network? Do you have friends you feel close to? Do they live locally?

Do you consider yourself to be spiritual or religious?

If yes, please describe your faith or beliefs

What are typical things you do for pleasure or enjoyment, and how often?

### **Section 7: Medical and Mental Health History**

Please describe your current physical health:

Please describe any significant past medical problems and treatments (e.g., illnesses, surgeries, accidents, etc.):

Do you exercise regularly? If so, how often and what type of exercise?

If you are not currently exercising, is it something that is important to you?

Do you currently have a primary care physician?

Primary Care Physician's Name, Address, and Phone (if applicable):

Do you wish to have your primary care physician contacted or involved in your mental health treatment?

Please list any psychiatric and non-psychiatric medications you are currently taking using the categories below:

Psychiatric:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>
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Nonpsychiatric:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>
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Who currently prescribes your psychiatric medications?

Which psychiatric medications have you been on in the past, if any?

What are your feelings about psychiatric medications if it were ever suggested to you/your parents/guardians that they may be helpful?

*Please let me know if you would like me to consult with your medication prescriber at any point in treatment.*

Please describe your past experiences in outpatient therapy as best as you can remember, if any:

Therapist Name	Dates of treatment (start & end dates)	Approx. # of sessions	Type of treatment (individual, etc.)	Reason for seeking treatment
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Please describe your past experiences in inpatient or day hospital programs, if any:

Facility/program	Dates of treatment (start . end dates)	Type of program	Reasons for seeking treatment
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If you have been in therapy before, what was helpful and/or not helpful about your time in therapy?

Were you sexually, physically, or emotionally abused at any point in your life?

Have you had any other significant life changing events or traumas that affected you either negatively or positively?

When you are feeling distressed (e.g. anxious, depressed, stressed, sad, overwhelmed, etc.), how do you typically cope/help yourself feel better?

Does anyone in your family (immediate and extended) struggle with mental illness? If so, please describe

### **Section 8: History of Suicidal Feelings**

Many people think about suicide on occasion. Have you had times in life where you were thinking a lot about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture. Please also mention any partial or inpatient hospitalizations.

### **Section 9: Other Symptoms**

How is your concentration?

How is your memory?

How is your appetite?

Have you gained or lost weight recently?

Is your appetite affected by emotional issues?

Have you had or do you currently have any issues with eating (bulimia, anorexia, etc.)? If so, when?

Do you have trouble falling asleep?

Do you wake up frequently during the night?

Do you wake up earlier in the morning than you would like?

Approximately how many hours of sleep do you get per night?

### **Section 10: Substance Use and Addictive Behaviors**

Do you use alcohol? If so, how often and how much do you drink? When? Where?

Do you believe your alcohol use may be a problem?

Do you believe you have ever had a problem with alcohol use? If so, when?

How often and how much do you use other non-prescribed drugs?

Do you believe your drug use may be a problem?

Do you believe you have ever had a problem with drug use? If so, when?

Has anyone else ever thought you had an alcohol or drug problem or thought you should cut down?

Do you struggle with other addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

Has anyone in your family had an alcohol or drug problem? Who?

### **Section 11: Childhood and School Experience**

Where were you born and raised?

How would you describe your childhood?

What was your school experience like? What were your relationships with peers like?

### **Section 12: Self Image**

As you see yourself, what are your strengths?

What are your weaknesses?

What would you most like to change about yourself?

### **Section 13: Therapy Goal & Other Things I Should Know**

What would you like to accomplish out of your time in therapy?

Please describe anything else that is important to know in understanding your life and your difficulties.

What feelings have you had while filling out this questionnaire?

*Thank you for completing this questionnaire. It will be very helpful in developing an organized an effective treatment plan.*