the Samaritan Center
Healing - Hope - Growth

311 W. High Street
Elkhart, Indiana 46516
www.elkhartsamaritan.org
Phone (574) 262-3597
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CONFIDENTIAL

Adolescent Initial Questionnaire
(ages 13 - 17)

(FOR ADOLESCENT TO COMPLETE to best of their ability)

Adolescent's Name: _____Date: _____ Age: _____

Date of Birth: ____/____/____Gender: _____ Adolescent email: _____

Address: _____

City: _____State: _____ Zip: _____ Adolescent Phone: (____) _____

Name of Mother: _____ Live with (Y or N) _____

Mother's DOB: ___/___/___ Address if different from above: _____

Parent/Guardian email: _____ Parent/Guardian phone: _____

Name of Father: _____ Live with (Y or N) _____

Father's DOB: ___/___/___ Address if different from above: _____

Parent/Guardian email: _____ Parent/Guardian phone: _____

Parent(s)/Guardians(s) Employer(s): _____

Parents relationship status: Single Partnered Married Separated Divorced Widowed

Do you (adolescent) work? ____Y ____N Where? _____

What school do you attend? _____ What grade are you in / going into? _____

If you have siblings, please list ages, gender, and where each sibling lives: _____

_____

How did you hear about the Samaritan Center? _____

Are you being required to seek counseling? ____Y ____N If yes, by whom? _____

Have you had other counseling or psychotherapy? ____Y ____N If yes, by whom? _____

Please list current: medication: _____ Dosage: _____

medication: _____ Dosage: _____

medication: _____ Dosage: _____

(please continue listing medications on back of page if needed)

Current Needs/Concerns

What are your reasons for wanting counseling? _____

When did these problems first start? _____

Since they started, have your problems: ____Stayed the same? ____Improved? ____Worsened?

What's the reason you think these problems happen? _____

_____

Has there been anything that has helped these problems before? _____

_____

What would you like to see different, better, or changed in your life? _____

_____

If faith or spirituality is a part of your life, do you see it as a source of strength____? Or a contributor to your stressors___? Would you like to discuss these beliefs/absence of beliefs during the course of therapy? ____Y ____N

List your strengths and things that you like to do or are good at: _____

_____

Please check concerns that apply to you:

___ Bereavement (grief)
___ Depression
___ Anxiety
___ Panic
___ Problems at school
___ Nervousness or shakiness
___ Defiant/Oppositional
___ Difficulty focusing/paying attention
___ Boyfriend/Girlfriend issues
___ Sexual concerns
___ Cries easily
___ Issues with eating
___ Illness of self or other person(s)
___ Hyperactivity
___ Religious/Spiritual doubts or fears
___ Intense anger
___ Low self-esteem
___ Physical abuse
___ Poor relationship with peers
___ Impulse control
___ Unusual feelings
___ Suicidal feelings or thoughts
___ Relationship issues with parents
___ Relationship issues with siblings
___ Tics/repetitive behaviors
___ Adjustment problems
___ Lies/steals
___ Loss of hope or meaning
___ Loss of self-respect
___ Hurts self on purpose
___ Fear
___ Decreased interest in things
___ Sleep Trouble or Nightmares
___ Alcohol/Drugs
___ Stomachaches/headaches
___ Afraid to be alone

Other: _____

Do you believe that you can be helped? ____Y ____N

(Circle or Check)

Please rate these statements:	**Strongly Agree**	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
I feel good about myself:	□	□	□	□	□
I can deal with my problems:	□	□	□	□	□
I feel I have control over my behaviors and actions:	□	□	□	□	□

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In the last 6 months how many times have you seen a medical professional? __Zero __1 __1-2 __4-5 __More

Do you have a serious medical condition or chronic illness? If so, please state: _____

_____

Is there anything else that you would like for us to know that we did not ask about on this form? _____

_____

_____

_____

Thank you for completing this form. Please bring it with you to your intake session to review with your therapist.