

A NEW START COUNSELING CENTER, INC.

ADOLESCENT QUESTIONNAIRE

TO BE COMPLETED BY THE ADOLESCENT BEING SEEN FOR COUNSELING

This information will help your therapist understand your concerns or questions. This, as well as all other communications with your therapist, will be kept confidential to the fullest extent of Georgia law.

BACKGROUND INFORMATION

DATE: _____

Name: _____

Age: _____

Why did you come to counseling? Describe any problems you are having now. If possible, list any questions you would like answered:

PROBLEM AREAS: In the following list, place a check mark next to each item which identifies an area of concern to you. Place two checks by those items which are most important.

- | | |
|--|---|
| <input type="checkbox"/> Anger/Temper | <input type="checkbox"/> Religious/Spiritual Concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Education/School Work | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Fighting w/brothers & sisters | <input type="checkbox"/> Use of Alcohol |
| <input type="checkbox"/> Fearfulness/Phobias | <input type="checkbox"/> Use of Drugs |
| <input type="checkbox"/> Insecure/Timid/Lack of Self-confidence | <input type="checkbox"/> Work |
| <input type="checkbox"/> Marital Problems/Conflicts | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Between parents, divorce | <input type="checkbox"/> Physical Problems |
| <input type="checkbox"/> Problems with accepting discipline | <input type="checkbox"/> Traumatic Stress |
| <input type="checkbox"/> Problems with Relationships with other Children | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Other(specify) _____ | |

In your past, have you ever been the victim of or witnessed any type of traumatic incidents?

If yes, please explain: _____

Please complete the following sentences with the first response that comes to mind:

1. Most of all I want _____

2. I'm different from others because _____

3. People are always _____

4. It would be funny if _____

5. Girls think I _____

6. Boys think I _____

7. My family _____

8. I worry about _____

9. I wish I could stop _____

10. When I grow up _____

11. I just can't _____

12. People shouldn't _____

13. I want to know _____

14. It hurts when _____

15. If I were a boy/girl _____

16. All my life I _____

17. My mother thinks I _____

18. My father thinks I _____

19. I get mad when _____

20. When I get mad, I _____

21. If I were older _____

22. If I were younger _____

23. I'm afraid of _____

24. When I'm afraid, I _____

25. I often wonder _____

26. Other children _____

27. Nobody knows _____

Signature: _____ Date: _____

