Adolescent Questionnaire

Confidential

Note: This form is optional! Any information you give me would help me to know more about you (rather than just what our parents say about you). If you would rather note, please feel free to answer only part or none of the questions.

Please DO NOT show your parents your answers.

Name: _____ Age: _____

Who's idea was it for you to come here?

( ) Mine
( ) Parent(s)
( ) Other:_____

How do you feel about being here?

( ) It's fine with me
( ) I don't care either way
( ) I'm against it

What would you say is the reason you are here? _____

_____

School

What school do you go to? _____

Anything particular you like about it? _____

Anything you don't like? _____

What activities (if any) are you in at school (such as sports, music, etc.)? _____

_____

What subjects are you strongest in? _____

What subject(s) are you weakest in? _____

Activities and Interests

What do you do for fun? _____

What kind of music do you listen to? _____

Do you have a current favorite artist, tape or song? _____

Friends

How much time do you spend with your friends?
( ) A lot of time
( ) Sometime
( ) Not much time

Do you have a "best" friend? ( ) Yes ( ) No
If so, how long have you known him/her? _____
Can you talk to this person about serious problems in your life? ( ) Yes ( ) No

Do you have a boyfriend or girlfriend? ( ) Yes ( ) No
If so, how long have you been dating? _____

Do people at school tend to label your group of friends (ie, skaters metalheads, preps, etc.)?
( ) Yes ( ) No
If so, what label would you be given? _____

Health

How would you rate your overall health? ( ) Good ( ) Fair ( ) Poor

Check all that apply to you:
( ) I have headaches once a week or more
( ) I have gained 10 lbs or more within the past 2 months
( ) I have lost 10 lbs or more within the last 2 months
( ) I have difficult falling asleep
( ) I wake up frequently during the night
( ) I wake up very early and I can't get back to sleep
( ) I feel tired much of the time
( ) I have a hard time concentrating
( ) My memory is not as good as it used to be

Breaking Free Counseling Services

Check all of the feelings that you often have:

( ) Happy	( ) Sad	( ) Angry
( ) Irritable/"touchy"	( ) Anxious/Nervous	( ) Bored
( ) Confused confident	( ) Shy	( ) "Hyped Up" / Energetic
( ) Guilty	( ) Depressed	( ) Worried
( ) Lonely	( ) Worthless	

Drug and Alcohol Use

How often do you…	Never	Tried	Rarely	Monthly	Weekly	Daily
Drink?	( )	( )	( )	( )	( )	( )
Smoke cigarettes?	( )	( )	( )	( )	( )	( )
Smoke marijuana?	( )	( )	( )	( )	( )	( )
Use other drugs?	( )	( )	( )	( )	( )	( )

Family

Fill in all that apply to you

How well do you get along with your:

Mother: _____

Father: _____

Stepmother: _____

Stepfather: _____

Brother(s): _____

Sister(s): _____

Stepbrother(s): _____

Stepsister(s): _____

Please list any major changes in your life in the past five (5) years : _____

_____

Is there anything else you want me to know about you? _____

_____

Thanks for filling this out. Your information will help me a lot in helping you and/or your family.
Please give this to the secretary when you're finished.

Breaking Free Services Inc. | 727-389-9558
Shari@BreakingFreeServices.com | BreakingFreeServices.com