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ADOLESCENT INFORMATIONAL QUESTIONNAIRE

Name: _____ Birth Date: _____ Gender: F M

Address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Email: _____

Current grade: _____

Emergency Contact (name and phone number): _____

Parent's Name: _____

Home/Work Phone: _____ Cell phone: _____

Email: _____ Occupation: _____

Parent's Name: _____

Home/Work Phone: _____ Cell phone: _____

Email: _____ Occupation: _____

Parent Relationship Status: Married Never married Separated Divorced Partner deceased

If divorced, who has legal custody: _____

Siblings, including step-siblings and half siblings:

Name: Age Gender

1.

2.

3.

4.

Other people living in the home (cousins, grandparents)

1.

2.

Please check any of the following that you have experienced in the past 6 months:

- | | | |
|--|---|---|
| <input type="checkbox"/> Increased/decreased appetite | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Repetitive behavior | <input type="checkbox"/> Abuse of alcohol/drugs | <input type="checkbox"/> Feeling stressed |
| <input type="checkbox"/> Feeling empty | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Extreme worry | <input type="checkbox"/> Feeling paranoid | <input type="checkbox"/> Depressed mood |
| <input type="checkbox"/> Increased fears | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Unusual/extreme euphoria |
| <input type="checkbox"/> Lack of energy/lethargy | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Increased fatigue |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Recklessness |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Violent actions | <input type="checkbox"/> Self-hate |
| <input type="checkbox"/> Too much energy | <input type="checkbox"/> Isolation from others | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Hearing voices that others don't |
| <input type="checkbox"/> Recurring thoughts | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Seeing things others don't |
| <input type="checkbox"/> Crying spells Increased anger | <input type="checkbox"/> Change in weight | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Sexual issues | <input type="checkbox"/> Increased fears | |

Other:

Has there been any history of abuse (physical, sexual, emotional)? Yes No

Is there any history of domestic violence in the home? Yes No

Has there been any history of suicidal ideation? Yes No

Has there been any previous suicidal attempts? Yes No

Has there been any history of aggressive behaviors toward others? Yes No

Psychological

Describe any past therapy experiences. What worked or didn't work?

Please indicate whether there are any relatives, including parents, grandparents, aunts, uncles and cousins who have the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses. (Please be as specific as possible, giving relationship to child, age and problem).

Mother's Family:

Father's Family:

Medication

Please list any medications that you are currently taking and describe why you are taking them:

Current problem

Describe the difficulties you are currently facing and how for how long:
(Include what you have tried in the past to help resolve the problem)

Please write any additional information you would like me to have as we begin our work together: