VICTORIA GOULD, PSY.D.

dr.vgould@gmail.com
860.480.8524

720 Hopmeadow St.
Simsbury, CT 06070

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:

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

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:

Please email completed form to: dr.vgould@gmail.com