KAISER PERMANENTE®

Northern California

☒ **Psychiatry**

MR #: ____________________

Name: ____________________

IMPRINT AREA

CPY ADOLESCENT QUESTIONNAIRE (12+)

PREFERRED NAME	AGE	PHONE

All responses are kept confidential (between you and your provider) unless you choose to release this form to someone, or report that you are considering seriously harming yourself or someone else, or someone has seriously harmed you or another child.

Please check the box or boxes that most closely describe you. Please use the blank lines to provide additional information.

WHOSE IDEA WAS IT FOR YOU TO BE SEEN HERE TODAY? ❑ Mine ❑ Parent(s) ❑ Other

IF SOMEONE OTHER THAN YOU, ARE YOU OKAY WITH THIS IDEA? ❑ No ❑ Yes ❑ Not sure

MAIN PROBLEM/MAJOR REASONS FOR SEEKING HELP AND WHEN THE PROBLEM BEGAN:

Please check the items below that are significant *current* problems for you.

Is it hard for you to focus and pay attention?

❑ **No (skip section)** ❑ **Yes (complete items below)**

- ❑ Make careless mistakes
- ❑ Problems paying attention/staying focused
- ❑ Often do not finish homework or chores
- ❑ Problems with organization
- ❑ Lose things easily
- ❑ Forgetful

Do you have a hard time controlling your words or behaviors?

❑ **No (skip section)** ❑ **Yes (complete items below)**

- ❑ Act without thinking
- ❑ Restless/Unable to sit still
- ❑ Talk a lot
- ❑ Problems waiting my turn
- ❑ Interrupt others

Are you feeling sad, depressed, or irritable?

❑ **No (skip section)** ❑ **Yes (complete items below)**

- ❑ Sad or depressed mood
- ❑ Irritable or grouchy
- ❑ Problems sleeping (falling or staying asleep)
- ❑ Tired a lot
- ❑ Loss of interest, pleasure, or motivation

Are you often worried or anxious?

❑ **No (skip section)** ❑ **Yes (complete items below)**

- ❑ Frequent headaches, stomachaches, or other pains
- ❑ Anxiety or worry (e.g., about past behaviors, future events, doing well)
- ❑ Phobia or extreme fear (e.g., scared of flying, heights, going over bridges)
- ❑ Thoughts/ideas that repeat over and over in your head
- ❑ Behaviors that you feel that you have to do over and over (e.g., counting, washing)

Are you often angry at others?

❑ **No (skip section)** ❑ **Yes (complete items below)**

- ❑ Blame others for my mistakes
- ❑ Angry most of the time
- ❑ Easily annoyed by others
- ❑ Go against adult requests or rules
- ❑ Back talk or argue with adults
- ❑ Enjoy "bugging" people
- ❑ Lose temper

Have you experienced or witnessed a traumatic event (i.e., car, accident, death, earthquake)?

❑ **No (skip section)** ❑ **Yes (complete items below)**

- ❑ Ongoing negative thoughts about what happened
- ❑ Ongoing negative feelings about what happened
- ❑ Recurrent distressing dreams about the event
- ❑ Flashbacks about the event
- ❑ Attempts to avoid memories, thoughts, or feelings about what happened

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Do you do things that get you in trouble?

❑ No (skip section) **❑ Yes (complete items below)**

- ❑ Bully or threaten others
- ❑ Get in physical fights
- ❑ Hurt animals
- ❑ Stole things
- ❑ Set fire
- ❑ Destroyed property
- ❑ Broke into a house, building, car
- ❑ Stay out all night
- ❑ Ran away
- ❑ Skip school
- ❑ Problems with the law or police

Do you feel that you have a problem with eating or body image?

❑ No (skip section) **❑ Yes (complete items below)**

- ❑ Fear of weight gain or being fat
- ❑ Trying to lose weight
- ❑ Unhappy with body weight or shape
- ❑ Purging/Self-induced vomiting
- ❑ Use of diet pills, laxatives, excessive exercise
- ❑ Overeat/Binge
- ❑ Feeling guilt, sadness, or disgust when I overeat
- ❑ Feeling that I cannot control my eating

Please describe the following *current or past* thoughts or feelings.

	Never or not at all	In the past	Sometimes	Often	All the time
I hurt or injure myself on purpose.	❑	❑	❑	❑	❑
I feel it is too painful to keep living or that I would be better off dead.	❑	❑	❑	❑	❑
I think about suicide.	❑	❑	❑	❑	❑
I thought about specific ways to kill myself.	❑	❑	❑	❑	❑
I tried to kill myself.	❑	❑	❑	❑	❑
I think about hurting or killing others.	❑	❑	❑	❑	❑
I hear voices or see things that are not there.	❑	❑	❑	❑	❑
I feel like people are out to get me.	❑	❑	❑	❑	❑

Please describe any *current* or *past* abuse.

	None	Verbal (put downs, controlling)	Physical (hits, threatens to hit)	Sexual (pressured or forced)
CHILD ABUSE	❑	❑	❑	❑
WITNESSED VIOLENCE AT HOME	❑	❑	❑	❑
DATING VIOLENCE	❑	❑	❑	❑
PEER VIOLENCE (bullying)	❑	❑	❑	❑
ONLINE VIOLENCE (sexting, cyber-bullying)	❑	❑	❑	❑

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Please describe your substance use.

	Never	Past use only	Rarely	Weekly	Daily
ALCOHOL	❑	❑	❑	❑	❑
TOBACCO	❑	❑	❑	❑	❑
MARIJUANA	❑	❑	❑	❑	❑
OTHER DRUGS: ______________	❑	❑	❑	❑	❑

EXERCISE PER *DAY* (average)	❑ 0	❑ 30 min.	❑ 1-2 hours	❑ 3 hours or more
MEDIA USE PER *DAY* (average hours) (e.g., social media, video games, phone, computer, TV)	❑ 0	❑ 1-2	❑ 3-4	❑ 5 or more
CAFFEINE DRINKS PER *DAY* (e.g., coffee, soda, energy drinks)	❑ 0	❑ 1-2	❑ 3-4	❑ 5 or more
SLEEP PER *NIGHT* (average hours)	❑ less than 5	❑ 6-7	❑ 8-10	❑ 11-12

Please describe your family (parents, step-parents, siblings) by completing the table below

NAME	RELATIONSHIP TO YOU	OUR RELATIONSHIP IS… Poor	Average	Good	OVERUSES DRUGS/ALCOHOL	SPENDS TIME WITH ME
Example: Mary	*Sister*	❑	☒	❑	❑	☒
		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑
		❑	❑	❑	❑	❑

Please describe you and your relationships.

TOTAL NUMBER OF FRIENDS	❑ None	❑ A few	❑ Average	❑ A lot
NUMBER OF CLOSE FRIENDS	❑ 0	❑ 1	❑ 2-3	❑ 4 or more
HOW I FEEL ABOUT MY FRIENDSHIPS	❑ Unsatisfied	❑ Neutral		❑ Satisfied
HOW I GET ALONG WITH PEERS	❑ Poor	❑ Average		❑ Good

RELIGIOUS/SPIRITUAL SUPPORTS: ______________________________

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Please describe you and your relationships.	**No**	**Yes**
DATING SOMEONE	❑	❑
SEXUALLY ACTIVE	❑	❑
PREGNANCY (PAST OR CURRENT)	❑	❑

SEXUAL ORIENTATION (e.g., straight, gay, bi): ____________________

GENDER IDENTITY AND PREFERRED PRONOUN (e.g., boy, he, they): ____________________

SCHOOL NAME: ____________________ GRADE: ____________________

SCHOOL PERFORMANCE ❑ Poor ❑ Average ❑ Above Average

SCHOOL PROBLEMS (check all that apply)
❑ Problems with teachers ❑ Learning problems
❑ Referrals ❑ Suspensions/Expulsions (#_________)
❑ Other school problems: ____________________

SCHOOL SUPPORTS (e.g., counselor, group, teacher): ____________________

What are you hoping to get out of being here (e.g., improve mood, help with anger, work on relationships)?

How important is this change for you? (Please circle a number.)

Not at all										**Completely**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please describe yourself: