Adolescent/ Parent Questionnaire

Part I: To be filled out (mostly) by parent

Name____
Address____Include zip code_________
Phone number of adolescent___________________________Message okay? ___________
Phone number of parent____________________________Message okay?___________
School (or school district) adolescent attends________________________On IEP plan?____ 504 Plan?____
Names of parent(s) or guardian____
Email of contact parent______________________May I e-mail you at this address?______

Date of birth of adolescent______________________age__________________________
Occupation of parents____
Referred by______________________________Phone_________________________________ May I have your permission to thank this person for the referral?_________________________ Is minor in individual psychotherapy? _____Who is the therapist?____________________

Background

Is the adolescent taking psychiatric medication? If yes, list medications,
____
____

Prescribed by __________________________Phone ___________________________________

Has the adolescent ever been hospitalized for psychiatric reasons or for drug/alcohol use? Please give names of hospital, dates of service, and reasons for hospitalization._____________________
____
____
____

What do you hope that your adolescent will get out of treatment? How do you imagine things being different for him/her if this treatment is helpful? __________________________________
____

Please defer to "forms" on website. Our signatures below indicates that we have had the opportunity to read and ask questions about:

____Notice of Privacy Practices/ HIPPA
____Adolescent/ Parent Consent 2018
____We understand that DBT group therapy is *one aspect* of intensive and comprehensive DBT treatment, and we are free to seek comprehensive DBT treatment in other settings.

Signature of adolescent____Date__________

Print Name____

Signature of parent (s)____Date__________

Print Name____

Part II: To be filled out by adolescent

What brings you to treatment today? ____
____

Rate below by circling a number on the continuum:

I really want to be here — I'm only here because someone else wants it

1 2 3 4 5 6 7 8 9 10

Group sounds really interesting — I hate the idea of being in a group

1 2 3 4 5 6 7 8 9 10

I wish I could change painful aspects of my life — I do not need to change anything

1 2 3 4 5 6 7 8 9 10

Therapy has been helpful to me before — No therapy has ever been helpful

1 2 3 4 5 6 7 8 9 10

Put a checkmark if any of the below applies to you within the last 6 months, and put a * if any has applied to you during your lifetime:

______Smoking ______Skipping classes ______Sexually active ______Problems with bullying _____Intense conflict w/ parents _____Problems w/ social media ______Problems with grades/ schoolwork ______Thoughts of suicide ______Suicide attempts ______Intentional self-harm. If yes, what did you use_______________ ______Problems with eating (purposely not eating, eating big amounts, purposely vomiting after) ______Drinking alcohol. If relevant, about how much do you drink?_______How often?______ ______Drug use.

Anything I did not ask that is relevant to why you are here?________________________________

What gender pronouns do you prefer?____

How much caffeine do you drink per day?____

Do you have access to social media/ iphone during the night?______________________________

How many hours a night do you typically sleep?____

If therapy was helpful, what would be different in your life?_______________________________
____

What do I need to know to help make this a good experience for you?_____________________
____

Are you involved in any after school activities that would create a conflict with attending group? If so, what part of the year are you active in these activities?

____