INTAKE QUESTIONNAIRE-ADOLESCENT

YOUR NAME: **DATE:**

DATE OF BIRTH: **AGE:**

Highest grade or level of education completed:

Current medications: Please state name, dose, how often taken, prescribing doctor. Include supplements:

1. What has led you to seek evaluation or treatment at this time?

2. What is your understanding of the disorder that is troubling you?

3. What do you know about treatment for this disorder?

4. Do you know anyone who has been diagnosed with your disorder? YES NO
   If yes, circle all the ways that they have been treated:

5. Ritalin or methylphenidate, Adderall, Antidepressant Individual Therapy Group Therapy Other medication:__________________________________(specify if known) Unknown Medication Not Sure

   Other:_____________________________

6. What are the greatest concerns that you have about your behavior at this time?

7. When would you say your problems began? (Circle one)
   a. 0-7 years
   b. 8-12 years
   c. 13-15 years
   d. 16-21 years
   e. 22 years to the present

IF YOU NEED MORE ROOM ON ANY PAGE, PLEASE USE OTHER THE SIDE.

Below you will find a table which list symptoms. Please tell me if they were ever more of a problem for you than for other people in your peer group and if so, now, state if it is better, worse or the same for you.

NOW IT IS:

SYMPTOM	YES	NO	SAME	BETTER	WORSE	COMMENT
Fidgetiness or feeling restless						
Difficulty remaining satisfied						
Being easily distracted						
Difficulty waiting your turn						
Blurting out answers before the question is completed						
Difficulty following through on or completing tasks						
Sustaining attention in tasks						
Frequently shifting from one task to another						
Difficulty doing tasks alone						
Talking too much						
Interrupting or intruding on others						
Not listening to others						
Losing important things or forgetting a lot						
Engaging in physically daring activities						
Always on the go, as if driven by a motor						
Making decisions too quickly or acting too quickly						
Impatient						

9. Did you ever seek treatment before for these problems? YES NO

If yes, when and where did you seek treatment?

What was the recommended treatment and the outcome?

QUESTION	YES	NO	COMMENT OR DETAILS
10. Did your parents take you to see some one about your problems when you were younger or recently?			
11. Do your parents complain that you are difficult to control?			If yes, at what ages did they complain you were difficult? 0-7 8-12 13-15 16-21 22+
12. Did you have trouble starting school in kindergarten or first grade?			
13. Did you ever repeat a grade?			If yes, what grade(s)?
14. Were you ever in any special classes in school			If yes, what kind?
15. Did your teachers think you did as well as you could?			Not sure what my teachers thought
16. Were you ever truant from school?			
17. Were you ever expelled or suspended from school?			
18. Did you ever get in any physical fights at school?			If yes in what grades: K-6th grade 7th or 8th grade High School Other
18a. How many times did you get into fights?			Once 2-5 times 6-10 times more than 10 times
18b. Sometimes I started the fight.			
18c. At least once I used a weapon in a fight.			
19. My best subject in school is:			
20. My worst subject is school is:			
21. Did you ever run away overnight?			
21a. If yes circle the number of times			Once 2-5 times 6-10 times More than 10 times
21b. Circle the longest time you ran away or were away from home			One night 2-5 nights 6-10 nights 10+ nights
22. Were you ever in trouble for stealing or damaging property?			
23. Have you ever been arrested or in			

trouble with the law?			
24. Do you have a drivers' license?			
24a. If yes, circle how many traffic tickets (not parking tickets) have you gotten?			None 1 2-3 4-5 6+
24b. While driving, how many car accidents have you *ever* been involved in.			None 1 2 3 4+
25. If you DO NOT have a drivers' license state in the comments section the reason or reasons.			
26. Do you have problems with your temper? Please provide details in the comment section			
27. Did you *ever* have problems with your temper?			I am not sure
28. Have you ever lost your temper enough to hurt someone or damage any property? If yes, please provide details in comment section.			
29. Do other people complain about your temper?			I am not sure.
30. My mood is stable and pretty normal			
31. My mood is anxious or nervous			
32. My mood is depressed, sad or blue			
33. My mood changes a lot, or goes up and down			
34. Do you have problems with sleep? If yes please give details in the Comments section.			
35. Do you have problems with your weight? If yes please give details in the Comments section.			
36. Do you ever use any diet preparations? If yes please give details.			
37. Do you drink alcohol at least once a week or more often? If yes please circle the amount you drink in a week in the Comments section			0-1 drink 2-4 drinks 5-10 drinks More than 10
38. Did you ever drink more heavily than you do now? If yes please give details.			
39. Have you ever used drugs recreationally? If yes, please circle all those that apply.			Pot (marijuana, hashish, grass) Amphetamines (stimulants, uppers, speed) Barbiturates (sedatives, downers, sleeping pills, Seconal, Quaaludes) Tranquilizers (Valium, Librium, etc) Cocaine

			Crack Heroin Opiates other than Heroin (Iodine, Demerol, morphine, methadone, Darvon, Opium) Psychedelics (LSD, mescaline, peyote, DMT, PCP) Other:
40. Do you use any drugs recreationally now? If yes, please state what drugs and how often in the Comments section.			
41. Have you ever misused any prescription drugs?			
42. Have you ever been accused of driving while under the influence of drugs or alcohol? If yes, please give details.			
43. Have you ever seen a counselor or psychiatrist in the past? If yes please give details, if they are not already given above.			
44. Have you ever been hospitalized for a psychological or psychiatric problem? If yes, please give details.			
45. Have you ever had problems with depression? If yes please give details.			
46. Have you ever had problems with anxiety? If yes, please give details.			
47. Do you have any current medical problems? If yes, please give details.			
48. Have you ever been hospitalized for medical reasons? If yes, please give details.			
49. Have you ever had any heart problems? If yes, please give details.			
50. Have you ever had any liver disease? If yes, please give details.			
51. Have you ever had glaucoma? If yes, please give details.			
52. Have you ever had any seizures? If yes, please give details.			
53. Do you have high blood pressure? If yes, please give details.			
54. Are you troubled by chest pain or shortness of breath? If yes, please give details.			
55. **Have you ever had an injury to your head?** If yes, please give details.			
56. Have you ever lost consciousness? If yes, please give details.			

57. Have you ever had encephalitis or a brain infection? If yes, please give details.			
58. Have you ever had or do you now have any tics or unusual movements of your body? If yes, please give details.			
59. Have you ever had or do have any vocal tics, or do you make any unusual noises or sounds (Tourette's Syndrome) If yes, please give details.			
60. If you are right handed place a R next to the activity, if left handed place an L next to activity, if ambidextrous, place an A next to the activity: Writing Kicking Throwing			
61. Have you ever had problems with your thyroid gland? If yes, please give details.			
62. As far as you know, were there any problems with your mother's pregnancy or delivery of you? If yes, please give details.			
63. As far as you know, did you walk, talk, and sit up on time? If no, please give details.			
64. Did you have any childhood illnesses? If yes, please give details.			
65. Do you have normal relations with your peers? If no, please give details.			
72. Do you have any allergies to anything? If yes, please give details.			
73. Are there any medical illnesses that run in your family? If yes, please give details.			
Is there anyone in your family who has or who in the past has had difficulties with any of the following problems: ***If yes, please give details for each.***			
74. Depression or anxiety			
75. Alcohol or drugs			

76. Psychiatric illnesses			
77. Trouble with the law			
78. Seizures or other neurological problems			
79. Tourette's syndrome or vocal tics			
80. A movement disorder or any unusual movements			
81. Heart problems			
82. High blood pressure			
83. Attention Problems			
84. Learning Disabilities			
85. Have you ever served in the military? If yes, your highest rank, special honors, duties and discharge status.			
88. Do you have trouble in your relationships with others? If yes, please provide details, e.g. what kinds of people, situations, etc.			
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90. How much do you smoke?
    a. Never smoked
    b. Have quit for more than a year
    c. Have quit for less than a year
    d. Less than half a pack a day
    e. Half to one pack per day
    f. One to two packs per day
    g. Two or more packs per day

91. How long have you smoked?

92. How much caffeine do you drink, including caffeinated tea and soda?

    a. None
    b. 1-2 cups a day
    c. 3-4 cups per day
    d. 5-6 cups per day
    e. 7-10 cups per day
    f. 11+ cups per day

Thank you for all of the information you have provided. However, despite our best efforts, sometimes we omit important questions. Is there anything that you can add that might be helpful to the doctor or that you think is important that has not been covered?