Riverstone Psychological Services
511 Northern Hills Dr NE, Suite #2
Rochester, MN 55906
(507) 923-7321

Adolescent Intake Questionnaire

Name: _____ Today's Date: _____

Below are several standard questions we ask in order to better serve you. Provide as much detail as you would like; you can verbally provide more detail at your appointment, if you wish.

Reason for Visit

What is the reason that brought you here today?

Did someone recommend you make this appointment? If so, who? _____
and why did he/she recommend making an appointment?

Demographics

Your Date of Birth: _____ Age: _____

Identified Gender (please circle): Male Female Other:_____

Identified Race: Identified Ethnicity:

County of Residence: Residential Status:

Current Life Situation

With whom do you currently live?

First name _____ Relationship to you _____ Age _____
First name _____ Relationship to you _____ Age _____
First name _____ Relationship to you _____ Age _____
First name _____ Relationship to you _____ Age _____
First name _____ Relationship to you _____ Age _____

Are you satisfied with your current living situation?

Do you live in an environment that is safe and free from verbal, emotional, or sexual abuse?

___ YES, ___ NO

What grade are you in school?

What is your parents' highest level of education?
___ Some high school (Last grade completed?) _____
___ High school graduate
___ Some college
___ College graduate
___ Some graduate level courses
___ Completed graduate degree(s)

Are you currently employed? ___ YES, ___NO, ___Student
___ Full-time, ___Part-time?

Briefly describe your social support network. Do you feel adequately supported in your relationships? Who are your main supports?

What is currently going well for you? What would you say are your strengths?

What do we need to know about your spiritual or cultural background in order for us to be helpful to you?

What makes the problem (that brought you here today) worse or harder to manage?

Do you currently use ___ alcohol, ___ tobacco, or ___other substances?

Do you have any concerns about your use of alcohol, tobacco, or other substances?

Have you ever used more than one chemical at the same time in order to get high?	YES	NO
Do you avoid family activities so you can use?	YES	NO
Do you have a group of friends who use?	YES	NO
Do you use to improve your emotions such as when you feel sad or depressed?	YES	NO
Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	YES	NO
Have you ever used alcohol or drugs to relax, feel better about yourself, or fit in?	YES	NO
Have you ever used alcohol or drugs while you are by yourself or alone?	YES	NO
Have you ever forgotten things you did while using alcohol or drugs?	YES	NO
Have your family or friends ever told you that you should cut down on your drinking or drug use?	YES	NO
Have your gotten into trouble while using alcohol or drugs?	YES	NO

How would you describe your current physical health?

When was your last physical exam? _____
What were the results?

Who is your primary care physician? _____

What primary care clinic do you use? _____

What medications are you currently taking? (Please include those you are taking for both physical and/ or emotional issues. Or, you may attach a list from your clinic.)

Have you ever had a head injury? ___ YES, ___ NO
If yes, please briefly describe.

Have you had any significant childhood injuries or illnesses? ___ YES, ___ NO
If yes, please briefly describe.

As a child, were you affected by maltreatment, trauma, or abuse? ___ YES, ___ NO

As an adult, were you affected by maltreatment, trauma, abuse? ___ YES, ___ NO

Have you ever struggled with addiction? ___ YES, ___ NO
If yes, please briefly describe.

Please list below the names and dates of any previous chemical or mental health treatment:

Name of Agency:	Reason for treatment:	Dates of treatment:

What medications (for mental health issues) have you tried in the past? What was the result?

Have you ever had thoughts of harming yourself/ someone else? ___ YES, ___ NO

Do you currently struggle with these thoughts? ___ YES, ___ NO

Has anyone in your family struggled with addiction or mental health?

Relationship to you Type of Problem

_____

_____

_____

Please describe any spiritual/ cultural/ family influences currently impacting you and/ or the problem that brought you here today:

What would you like to accomplish in your time here at Riverstone?

Thank you for taking the time to complete this questionnaire. Please return it at your next appointment.

OFFICE USE ONLY

Primary:	ICD 9 CODE	DSM-5 CODE
Secondary:	ICD 9 CODE	DSM-5 CODE
Tertiary:	ICD 9 CODE	DSM-5 CODE