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 Rochester, MN 55901
 (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 you 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

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?

Are you cautious and careful about how you do things? No/Yes If yes, please explain _____

Do you like to plan ahead? Do you think before acting? No/Yes If yes, please explain _____

Are you able to postpone or delay an immediate gain? Are you able to easily inhibit an impulse? No/Yes If yes, please explain _____

Are you likely to not reveal your opinion immediately until you get to know someone better? No/Yes If yes, please explain _____

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