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HEALTHYFOUNDATIONSGROUP.COM

Patient Name: ______________________________
Patient Date of Birth: ____/ ____/ ________

Adolescent Addendum (Parent)

Yes / No — Are both parents living in the same household?
If no, please describe the current living arrangement/custody agreement:
____
____
____

Yes / No — Has your child exhibited any self-destructive behavior?
If yes, please describe: ____
____
____

Yes / No — Have you any concerns that your child has hurt himself/herself?
If yes, please describe: ____
____
____

Yes / No — Are you concerned about depression in your child?
If yes, please describe: ____
____
____

Yes / No — Do you suspect that your child may be using alcohol or drugs?
If yes, please describe: ____
____
____

Yes / No — Has your child been sexually active, pregnant, or responsible for a pregnancy?
If yes, please describe: ____
____
____

Yes / No — Do you have concerns relating to you child's sexual orientation?
If yes, please describe: ____
____
____

Patient Name: ______________________________
Patient Date of Birth: ____/ ____ / ________

Yes / No Has your child ever been involved with the police or juvenile justice authorities?
If yes, please describe: ____
____
____

Yes / No Has your child ever been bullied or harassed?
If yes, please describe: ____
____
____

How many hours in an average day does your child spend using electronics?__________
____
____

Describe any concerns you have about your child's weight or eating habits:___________
____
____

How does your child relate to other teenagers? ___________________________________
____
____

How do you feel about his/her peer group? _______________________________________
____
____

How does your child spend his/her free time? ____________________________________
____
____

With whom does your child share personal information? __________________________
____
____

Patient Name: ______________________________
Patient Date of Birth: ____/ ____ / ________

Adolescent Addendum
(Client)

Yes / No Have you exhibited any self-destructive behavior?
If yes, please describe: ____
____
____

Yes / No Have you intentionally hurt yourself?
If yes, please describe: ____
____
____

Yes / No Are you concerned about depression?
If yes, please describe: ____
____
____

Yes / No Have you ever used alcohol or any other drugs?
If yes, please describe: ____
____
____

Yes / No Have you been sexually active, pregnant, or responsible for a pregnancy?
If yes, please describe: ____
____
____

Yes / No Do you have concerns relating to your sexual orientation?
If yes, please describe: ____
____
____

Identity:
___Female ___Male __Other:_______________________

Orientation:
___Female ___Male __Other:_______________________

Yes / No Have you ever been involved with the police or juvenile justice authorities?
If yes, please describe: ____
____
____

Yes / No Have you ever been bullied or harassed?
If yes, please describe: ____
____
____

How many hours in an average day do you spend using electronics? _________________
____
____

Describe any concerns you have about your weight or eating habits:_________________
____
____

How do you relate to other teenagers? ____
____
____

How do you feel about your peer group?
____
____
____

How do you spend your free time? ____
____
____

With whom do you share personal information?___________________________________
____
____

Name: ____________________________ **Date:** __________

Over the last 2 weeks, how often have you been bothered by any of the following?	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed,or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Name		Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the **past 6 months**.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult