California ADHD Center for Success

12625 High Bluff Drive #201 * San Diego, CA 92130
Phone (858) 481-4988 * Fax (858) 400-5204

Teen/Young Adult History Questionnaire (completed by teen/young adult)

Please complete the following questionnaire to give me a general understanding of the various aspects of your life.

Name: _____ **Birth date:** _____**Age:**_____ **Driver's License #**_____

Name of parent/guardian: _____

Home Address: _____

City: _____ **State:**_____ **Zip Code:**_____ **Today's date:**_____

Home Phone: ( ) ____- _____Cell Phone: ( ) ____- _____ e-mail:_____

Is it OK to receive email regarding appointments yes/no

it OK to leave a voicemail at: home yes/no **mobile** yes/no **work** yes/no

Emergency Contact's name: _____ **Phone: ( ) ____- _____**

Birthplace: _____ **Religious affiliation:**_____ **Pronouns:** she/her he/him they/them

Current reason(s) for seeking an evaluation now:

_____

_____

List three issues that concern you most:

- _____
- _____
- _____

When did you first notice these issues?

_____

_____

What have you already tried to resolve these issues/conditions?

_____

_____

What has helped? What has not been helpful?

_____

_____

What worries you most if things stay the way they are?

_____

_____

_____

List the most stressful things in your life that are affecting you right now:

- _____
- _____
- _____

What would you like to see happen as a result of this evaluation?

_____

_____

Therapy History

Have you previously seen a therapist? □yes □ no

If so, who did you see and how old were you?_____

If yes, what did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Family History

Are both of your parents living? □yes □ no

Are your parents: □ married □ divorced □ remarried

Have either of your parents been diagnosed with ADHD? □Mother □ Father

If not, do they have symptoms? If yes, please describe.

_____

_____

_____

Do you have any siblings? □yes □ no How many? _____

Have any of them been diagnosed with ADHD? □yes □ no If yes whom? Please list their name(s) and age(s)

_____

_____

_____

Are you organized? Please describe your skills, including how you manage your room/desk/work space.

_____

_____

Do you have any difficulty with time management? (always late or in a hurry? procrastinate assignments or tasks, have difficulty planning, etc?) Please describe below.

Please check any concerns that your family is currently experiencing:

☐ fighting	☐ feeling distant	☐ loss of fun	☐ lack of honesty
☐ physical fights	☐ financial problems	☐ death of a family member	☐ abuse/neglect
☐ housing problems	☐ job change/loss	☐ alcohol use	☐ drug use
☐ parent having affair	☐ divorce/separation	☐ issues with remarriage	☐ new sibling
☐ health issues	☐ other_____	☐ other_____	☐ other_____

Social History:

List some of the good qualities you like about yourself:

_____

_____

Do you make friends easily? □yes □ no

I consider myself socially (check all that apply): □ outgoing □ shy □ leader □ follower □ loner □ socially popular □ comfortable with my social group □ an outcast □ picked on/ teased

Have you ever been bullied? □yes □ no If so, by whom?

_____

_____

Do you have a best friend? □yes □ no

Are you happy with the amount of friends you have? □yes □ no

Are your parents happy with your friends? □yes □ no

To what extent can you rely on your friends for support?_____

_____

Are you involved in any organized social activities (e.g. sports, scouts, music)? □yes □ no

If so, what?_____

_____

What do you like to do in your free time?

_____

_____

Are you dating? □yes □ no Are you currently in a relationship? □yes □ no

If so, how long have you been in this relationship?

Are you sexually active? □yes □ no If yes, do you use birth control? □yes □ no

Do you consider yourself: □ heterosexual □ gay □ lesbian □ bisexual □ transgender □ questioning

Are your parents aware of your sexual preference? □yes □ no

Are you working? □yes □ no What do you do?_____

How many hours a week?_____ Do you enjoy your job? □yes □ no

Do you have a history of trauma? (i.e. sexual assault, been in an accident, witnessed violence, history of physical abuse, emotional abuse) □yes □ no

If so, please share what you would like to about that trauma/incident._____

_____

_____

School History:

Current grade_____ School (name)_____ □ public □ private □ other

Do you like school? □yes □ no Do you attend school regularly? □yes □ no

What are your current grades:_____

How do you approach homework? (procrastinate? rush through it? Need assistance to understand?) Please describe below.

Last grade completed:_____ □ High School Diploma □ GED □ Vocational Training □ College_____

Do you have any learning challenges? (ADHD, Learning Disability, Dyslexia, etc.)_____

_____

Do you currently or have you had an: □ IEP □ 504 □ GATE Program

Lifestyle Behaviors:

Do you have any current physical concerns or chronic health conditions? □yes □ no

Please describe:_____

_____

What medications do you take, including vitamins, natural products, etc:_____

_____

Do you take your prescribed medications daily? □yes □ no

Do you suspect you may misuse any prescription medication? □yes □ no

How would you describe your current physical health? □ very healthy □ mostly healthy □ moderately healthy □ often sick □ almost always sick

How well do you sleep: □ very well □ pretty well □ ok □ poorly

I sleep: □ too much □ not enough □ have trouble falling asleep □ have trouble staying asleep

How often do you exercise: □ daily □ couple times a week □ occasionally □ rarely

What do you do for exercise?_____

Do you drink caffeine? □yes □ no If so, what (soda, coffee, etc.)?_____

Do you have any concerns around your eating habits? □yes □ no If yes, please describe:_____

_____

How do you feel about your body?

_____

_____

Have you ever had an eating disorder or experienced issues with food/eating?

_____

Individual Concerns:

Please check any you have experienced in the past 6 months.

SYMPTOM	NONE	MILD	MOD	SEVERE	**SYMPTOM**	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					SOCIAL ISOLATION				
SLEEP DISTURBANCES					PARANOID THOUGHTS				
PROBLEMS AT HOME					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/ PURGING					LOW ENERGY				
LONLINESS					EXCESSIVE WORRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/ INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
CUTTING					RACING THOUGHTS				
IMPULSIVITY					RESTLESSNESS				
NIGHTMARES					DRUG USE				
HOPELESSNESS					ALCOHOL USE				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					OBSESSIVE THOUGHTS				
ANOREXIA					PANIC ATTACKS				
GRIEF					FEELING ANXIOUS				
PHOBIAS					FEELING PANICKY				
HEADACHES					SUICIDAL THOUGHTS				
WEIGHT CHANGES					PAST SUICIDE ATTEMPTS				

Please check items of concern to you:

- ☐ anxiety/nervousness
- ☐ shyness
- ☐ social problems
- ☐ stress
- ☐ anger
- ☐ fear making mistakes
- ☐ explosive temper
- ☐ low energy
- ☐ high energy
- ☐ unhappy most of the time
- ☐ cry too often
- ☐ body image
- ☐ death of a pet
- ☐ sadness
- ☐ difficulties concentrating
- ☐ loneliness
- ☐ low self confidence
- ☐ low self esteem
- ☐ obsessive thoughts
- ☐ unusual thoughts
- ☐ frequent headaches
- ☐ frequent stomachaches
- ☐ frequent illness
- ☐ other_____

Drug/Alcohol History:

Do you currently use alcohol? □yes □ no

If yes, how often? □ daily □ 1-2x weekly □ socially □ occasionally □ rarely

If so, how much and what do you typically drink?

_____

Do you currently smoke marijuana? □yes □ no

If yes, how often? □ daily □ 1-2x weekly □ socially □ occasionally □ I've tried it

Have you ever smoked cigarettes? □yes □ no Do you currently smoke? □yes □ no

If so, how much per day?_____

Have you ever/do you engage in any of the following: □ Vape □ Chew Tobacco □ Electronic Cigarettes

□ Other_____

Where and when do you typically use?_____

What does using do for you?_____

_____

Does your personality change when you drink? □yes □ no How?_____

Have you ever felt you have needed to cut down on alcohol/pot/substance use? □yes □ no

Have you ever felt annoyed by criticism from others about your alcohol/pot/substance abuse? □yes □ no

Have you ever felt guilty about your alcohol/pot/substance abuse? □yes □ no

Have you ever used alcohol/pot or another substance to get the day started? □yes □ no

Who in your family (not or in the past) has had a problem with drugs or alcohol?_____

Is there anything else that you think we should know about that is related to your attention/focus., or anything else?

_____