NEW ENGLAND CENTER FOR ANXIETY

Questions for Children or Teens

1. Basic Personal Information

Name: Today's Date:

Age: Date of Birth:

What grade are you in? What school do you go to?

In what town or district is your school?

Do you have a part-time job? If so, what is it like?

2. Current Problems

Please describe the key problems for which you are currently seeking treatment and when they began. Please feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

3. Your Family and Living Environment

Please describe the personalities and styles of the people at home and your relationship with them.

Please describe the level of conflict, tension, or stress at home between your parents, between you and your parents, and between siblings.

What are things at home that may contribute to your difficulties?

Please describe with what emotional or mental health problems others in your family seem to struggle.

4. School Environment

Please describe what school is like for you and what things about school may contribute to your difficulties.

What are your typical grades?

How do you tend to get along with teachers?

How do you tend to get along with peers?

How much bullying or negativity have you experienced?

5. Friends and Social Environment

How would you describe your friendship network?

What are typical things you do for pleasure or enjoyment, and how often?

How do you think issues with friends or peer relationships contribute to your difficulties?

6. Medical History
Please describe your current physical health and any current problems with it.

7. Mental Health Treatment History
Have you seen a counselor or psychologist before? What was it like? What was bothering you at the time?

Have you ever been in an inpatient or day hospital program? If so, what was that like? What led you to go?

8. History of Self-Injury and Suicidal Feelings
Sometimes people hurt or injure themselves when they are upset or stressed. Do you do anything like that?

Many people think about suicide on occasion. Have you had times in life where you were thinking a lot about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture.

Have you ever been so upset that you thought about hurting others?

9. Other Symptoms
How is your concentration and memory?

How is your appetite?

How is your sleep?

When do you go to bed on average? When do you wake up on average? Avg. total hours of sleep?

Are there any issues about your gender or sexual development that cause you concern or that you would like to note?

10. Substance Use and Addictive Behaviors

How often and how much do you drink alcohol, use marijuana (pot), or do other drugs? Do you believe your alcohol or drug use may be a problem or ever was a problem?

Are there any issues related to substance abuse or addiction that trouble you?

11. History of Your Development and Other Major Stressors

Where were you born?

Please note different places or towns you have lived and what they were like.

Please note significant challenges or problems you have faced in your life.

Were you sexually, physically, or emotionally abused at any point in your life?

12. Technology Use

Tell us about what types of technology you use (cell phone, ipad, internet, facebook, video games, etc).

How much time per week do you spend using each of these technologies?

Do you think that you spend too much time?

12. Other Things Your Clinician Should Know

Please describe anything else that is important to know in understanding your life and your difficulties.

Thank you for completing this Questionnaire. We expect it will be very helpful in getting to know you.