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Young Adult Psychological Evaluation Questionnaire

Name:_____ Today's Date:_____

Gender: M F Date of Birth: _____

Address: _____

Email:_____

Best phone number to be reached:_____

School:_____ Grade/Year: _____

Parent's Name/s:_____ Age:_____

Occupations:_____

Are your parents: Married (how long? _____)

Divorced (date of separation? _____)

Single Parent

Siblings: Name Age Grade and School

Who do you live with? (include visitation arrangements):

What is your sexual orientation? Straight Gay Undecided/In Process

Do you have any religious affiliation?

Are you involved in a romantic relationship? Have you ever been?

Please describe your strengths (what you feel you are good at, not just academically, but all around – arts, athletics, activities).

What are your passions? What do you love to do?

Please describe the challenges you face (academic, social, concentration):

What extracurricular activities are you involved in?

What classes do you take?

At the present time, what are your main concerns? What can I help you with?

Health Information

Do you have any sleep difficulties? Do you sleep too much? Not enough? Have trouble falling or staying asleep? Have you ever? Please describe.

What is your relationship to food? How are your eating habits?

Is there any history of eating disorders?

Have you ever had surgery or been hospitalized? Yes No

If yes:

Problem	Date	Duration of Stay

Do you take any medication on a regular basis? If yes, please list below:

Please list any **allergie**s and treatment:

Educational Information

Please list schools attended and your progress at each (end with current school):

School Name	Grades Attended	Achievement Level/ GPA

Have you had any trouble in school? With classes? Socially?

Please check off which you've had experience with:

	Yes	No	When?
Psychoeducational Evaluation			
Committee on Special Education Classification			
Special education classes			
Modifications on tests			
Tutoring outside of school			
Difficulty completing HW			
Attendance issues			
Suspension/Expulsion from school			

Explain:

Mental Health Information

Have you ever had counseling in school, therapy, or psychiatric treatment? Yes No

Name of Counselor/Therapist	Dates of Treatment	Frequency of visits (e.g. 1x/wk)	Type of treatment (e.g. individual, group, family)

Family History:

To your knowledge, does anyone in your family have problems with depression, anxiety, drug abuse, learning issues?

Please explain (e.g. brother has ADHD, treated with medication; paternal grandfather – undiagnosed depression and alcoholism):

How would you describe your alcohol and drug use? Frequent occasional don't use

Please elaborate: