Columbia Addictions Center
Eileen Dewey, LCSW-C
Director

Adolescent History Questionnaire

Please take a moment to fill this out in regards to any questions or concerns you may have about your son/daughter and their visit today.

Son or Daughter's Name _____

Parent Name _____

Phone _____

E-mail _____

Briefly state the concerns you are having with your son/daughter?

_____

_____

_____

What attempts have been made to solve these problems?

_____

_____

_____

What kinds (if any) of drugs, alcohol, or paraphernalia have you found?

How long has the problem been going on?

Check any other concerns you may have:

- ☐ Behavioral
- ☐ Academic
- ☐ Psychiatric
- ☐ Friends
- ☐ Other

What specific situations concern you most?

On a scale of 1-10, how concerned on you? (10 being the most concerned.)

1 2 3 4 5 6 7 8 9 10

Has your teen previously attended counseling?

Reason: _____

When: _____

With Whom: _____

What would you like to see come out of today's meeting?

_____

_____

_____

What would you like to happen in terms of your child's treatment here at CAC?

_____

_____

_____

Additional Comments and/or Concerns:

_____

_____

_____

Thank you for your input