### AUBURN MFT CLINIC: Family Adolescent Intake

This section will focus on your individual symptoms related to depression and anxiety over the last 2 weeks.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling bad about yourself, or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed; Or being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Not Difficult</th>
<th>Somewhat</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>How difficult have these problems made it for you to do</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>your work, take care of the home, or get along with others?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Not Difficult</th>
<th>Somewhat</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>How difficult have these problems made it for you to do</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>your work, take care of the home, or get along with others?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using the following key, how often did YOU do the following during the past four weeks?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Threw something (but not at a family member) or smashed something</td>
</tr>
<tr>
<td>2. Threatened to hit or throw something at a family member</td>
</tr>
<tr>
<td>3. Threw something at family member</td>
</tr>
<tr>
<td>4. Pushed, grabbed, or shoved a family member</td>
</tr>
<tr>
<td>5. Hit (or tried to hit) a family member but not with anything hard</td>
</tr>
<tr>
<td>6. Hit (or tried to hit) a family member with something hard</td>
</tr>
</tbody>
</table>

Using the same key as above, how often did YOUR PARENTS do the following during the past four weeks?

<table>
<thead>
<tr>
<th>Using the following key, how often did YOUR PARENTS do the following during the past four weeks?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Threw something (but not at a family member) or smashed something</td>
</tr>
<tr>
<td>2. Threatened to hit or throw something at a family member</td>
</tr>
</tbody>
</table>
How true are the following statements?

1=Never
Almost never true
5=Very often
Always

true
1. I enjoy doing things and talk with peers ................................................................. 1 2 3 4 5 6 7
2. I get into conversations with adults (e.g., teachers, staff) at the school ...................... 1 2 3 4 5
3. I share feelings and ideas with peers........................................................................... 1 2 3 4 5
4. I actively participate in topic clubs (e.g., political, history, science, honors) ............... 1 2 3 4 5
5. I talk to teachers and staff about things other than class ........................................... 1 2 3 4 5
6. I actively participate in the school newspaper or yearbook ........................................ 1 2 3 4 5
7. I help other students who might need assistance (e.g., lost, sick, or hurt) ................. 1 2 3 4 5
8. I ask questions in class when I don’t understand the material .................................... 1 2 3 4 5
9. I actively participate in drama (e.g., school plays) or music (e.g., band)..................... 1 2 3 4 5
10. I express liking and caring for my friends ................................................................ 1 2 3 4 5
11. I actively participate in student government .............................................................. 1 2 3 4 5
12. I join in class discussions. .......................................................................................... 1 2 3 4 5
13. I am comfortable joking with teachers and staff ......................................................... 1 2 3 4 5
14. I actively participate in school sports/athletics (e.g., volleyball, track, football) ....... 1 2 3 4 5

Please circle the most accurate answer applicable for your intimate partner relationship for the last month.

1. All I see ahead of me are bad things, not good things..................................................... 1 2 3 4
2. There’s no use in really trying to get something I want because I probably won’t get it... 1 2 3 4
3. I might as well give up because I can’t make things better for myself .......................... 1 2 3 4
4. I don’t have good luck now and there’s no reason to think I will when I get older ....... 1 2 3 4
5. I never get what I want, so it’s dumb to want anything ................................................... 1 2 3 4
6. I don’t expect to live a very long life ................................................................................ 1 2 3 4

The next section will focus on your behavior in the family.

Please rate the degree to which you have experienced the following problems in the past 30 days.

Not at All  Once or twice  Several times  Often  Most of the time  All of the time

1. Arguing with others ........................................................................................................ 0 1 2 3 4 5
2. Getting into fights ......................................................................................................... 0 1 2 3 4 5
3. Yelling, swearing, or screaming at others .................................................................... 0 1 2 3 4 5
4. Fits of anger .................................................................................................................. 0 1 2 3 4 5
5. Refusing to do things teachers or parents ask ................................................................ 0 1 2 3 4 5
6. Causing trouble for no reason ..................................................................................... 0 1 2 3 4 5
7. Using drugs or alcohol .................................................................................................. 0 1 2 3 4 5
8. Breaking rules or breaking the law (out past curfew, stealing) .................................. 0 1 2 3 4 5
9. Skipping school or classes ............................................................................................ 0 1 2 3 4 5
10. Lying ........................................................................................................................... 0 1 2 3 4 5
11. Can’t seem to sit still, having too much energy ............................................................ 0 1 2 3 4 5
12. Hurting self (cutting or scratching self, taking pills) .................................................... 0 1 2 3 4 5
13. Talking or thinking about death .................................................................................. 0 1 2 3 4 5
14. Feeling worthless or useless ....................................................................................... 0 1 2 3 4 5
15. Feeling lonely and having no friends .......................................................................... 0 1 2 3 4 5
16. Feeling anxious or fearful ......................................................................................... 0 1 2 3 4 5
17. Worrying that something bad is going to happen.......................... 0 1 2 3 4 5
18. Feeling sad or depressed....................................................... 0 1 2 3 4 5
19. Nightmares ........................................................................... 0 1 2 3 4 5
20. Eating problems ...................................................................... 0 1 2 3 4 5

Please rate the degree to which your problems affect your current ability in everyday activities.

The next section will focus on health and sleep. Would you be willing to report your:

Height: _______  Weight: _______

1. During the last month how many times have you visited medical providers such as primary care or family doctors, internists, surgeons or medical specialists, physicians assistants or medical nurse practitioners as an outpatient? ____________________________

2. During the last month how many nights have you stayed in a hospital? ____________________________

3. Do you have a chronic illness? Circle the best answer.  NO  YES  If yes, please specify: ____________________________

How often during the past 4 weeks did you...

<table>
<thead>
<tr>
<th>Activity</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Get enough sleep to feel rested upon waking in the morning? ..........</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Awaken short breath or with a headache?.................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Have trouble falling asleep? .............................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Awaken during your sleep time and have trouble falling asleep? ......</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Have trouble staying awake during the day? ................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Get the amount of sleep you needed? .....................................</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The section will focus on demographics.

4. What is the highest level of education you attained? Circle the best answer.
   A. Junior High School or less   B. GED/High School   C. Vocational/Technical School

5. What is your sexual orientation? ________________________________

6. What is your current religious/spiritual preference? ________________________________

7. Do you consider yourself to be: Circle best answer.
   A. Not religious/spiritual   B. Slightly religious/spiritual   C. Moderately religious/spiritual
   D. Very religious/spiritual   E. Strongly religious/spiritual

8. What spiritual/religious activities do you and your family do on a regular basis together? Circle all that apply.
   A. Walk/Exercise   B. Pray or Fast   C. Attend worship services
   G. Pray for Partner/Spouse   H. Attend Spiritual/Religious Retreats   I. Volunteer Religion/Community

9. List any current physical health problems ________________________________

10. List Prescription, herbal, or over-the-counter medications including dosage and prescriber
    ________________________________

11. If you have any current or previous experiences with counseling or therapy, provide the following information.
    Name of counselor or agency: ________________________________
    Reason for counseling: ________________________________
    # of sessions: ________________________________
    How helpful was counseling?
    Not at all   Somewhat helpful   Very helpful
    1   2   3

12. Answer the following questions for your current family in which you live. SEVERITY = The IMPACT on YOU.
    In your childhood and family years, were there problems with:
    ________________________________
    Severity  Mild  Moderate  Severe
    Frequency  Once  Some  Often
    1. Emotional Abuse: Swearing, insults, threats .......................................................... N/A  1  2  3
    2. Physical Abuse: Slapping, hitting, throwing things .................................................. N/A  1  2  3
    3. Sexual Abuse: Being touched or touching someone sexually, forced sex .................. N/A  1  2  3
    4. Emotional Neglect: Unloved, ignored, rejected .................................................... N/A  1  2  3
    5. Physical Neglect: Not properly clothed, not fed, not taken to doctor (not due to poverty) ......... N/A  1  2  3
    6. Mother Was Treated Violently: She was pushed, bit, slapped, kicked, punched, threatened with knife/gun .......................................................... N/A  1  2  3
    7. Substance Use and Abuse: Alcohol abuse, drug use, or prescription abuse.................. N/A  1  2  3
    8. Household Mental Illness: Depression, mental illness .............................................. N/A  1  2  3
    9. Attempted Suicide or Suicide ......................................................................................... N/A  1  2  3
    10. Incarcerated Household Member ..................................................................................... N/A  1  2  3
    11. Parental Separation or Divorce ..................................................................................... N/A  1  2  3
    12. 

    In your childhood and family years, were there problems with:
    ________________________________
    Frequency
    Once  Some  Often
    1. Emotional Abuse: Swearing, insults, threats .......................................................... N/A  1  2
    2. Physical Abuse: Slapping, hitting, throwing things .................................................. N/A  1  2
    3. Sexual Abuse: Being touched or touching someone sexually, forced sex .................. N/A  1  2
    4. Emotional Neglect: Unloved, ignored, rejected .................................................... N/A  1  2
5. **Physical Neglect**: Not properly clothed, not fed, not taken to doctor (not due to poverty) ...... N/A 1 2 3

6. **Mother Was Treated Violently**: She was pushed, bit, slapped, kicked, punched threatened with knife/gun ........................................................................................................ N/A 1 2 3

7. **Substance Use and Abuse**: Alcohol abuse, drug use, or prescription abuse................................ N/A 1 2 3

8. **Household Mental Illness**: Depression, mental illness ......................................................... N/A 1 2 3

9. **Attempted Suicide or Suicide**: ................................................................................................. N/A 1 2 3

10. **Incarcerated Household Member**: .......................................................................................... N/A 1 2 3

11. **Parental Separation or Divorce**: ............................................................................................. N/A 1 2 3

13. How much did someone else pressure you to come for therapy? **Circle the best answer.**

   Not at all  A little pressure  Somewhat pressured  Quite pressured  Very pressured

14. Starting with the most important, please list the problems that brought you to therapy?

   A. ______________________________   B. __________________________________   C. _____________________________

15. Do you consider the problems that brought you to therapy to be the responsibility of:

   A. Yourself   B. Your parents   C. Another family member

16. Are you currently in counseling with one or more other therapists? **Circle the best answer.**

   YES  NO