



## CONNECTIONS THERAPY CENTER

### Adolescent Assessment – Parent

1047 Cannell Court, Rockton, IL 61072

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1. Have you noticed changes in the past few months regarding your adolescent's motivation, school grades, mood swings, or overall behavior? (e.g. withdrawn, angry, sad)

Yes  No

2. Does your adolescent have any special learning needs? (e.g. ADHD, ADD, Learning Disabilities)

Yes  No

3. Does your adolescent have problems which might be a result of a traumatic event in his/her life?

Yes  No

4. Do you suspect your adolescent of using alcohol or drugs?

Yes  No

5. Is your adolescent resistant to or refusing to follow family rules or your parenting?

Yes  No

6. Does your adolescent seem depressed or withdrawn?

Yes  No

7. Is your adolescent showing problems controlling his/her anger, or has he/she been destructive to property?

Yes  No

8. Is your adolescent struggling in school with lack of motivation, truancy, fighting, or other poor behavior?

Yes  No

9. Have you reason to suspect that your adolescent has been stealing from you or others?

Yes  No

10. Does your adolescent attempt to avoid consequences by manipulating people or situations, while blaming others for his/her difficulties?

Yes

No

11. Has your adolescent left your home without your permission, or stayed away longer than a couple of hours without your knowing where he/she was? Or has your adolescent told you he/she was going one place, and you found out later he/she was somewhere that you would not have approved of?

Yes

No

12. Have you ever been concerned that your adolescent might be thinking about committing suicide?

Yes

No

13. Has your adolescent exhibited symptoms of an eating disorder?

Yes

No

14. Has your adolescent's behavior ever resulted in any involvement with the police or the courts?

Yes

No

15. Has your adolescent ever been bullied?

Yes

No

16. Has your adolescent suffered a recent breakup with a partner?

Yes

No

17. Does your adolescent experience anxiety?

Yes

No