

Teen's Questionnaire

Name: _____

Address: _____

Telephone: _____ E-mail or parents email: _____

Age: _____ Birthday: _____ Place of Birth: _____

Height: _____ Weight: _____ Grade/
Teacher: _____

On a scale of 1-10 with 10 being the best and 1 being the worst, how are you feeling today?

Do you enjoy school? Please explain and tell me your favorite and least favorite part.

Do you have a large or small group of friends? _____

Who are your friends?
Do you have a best friend?

What do you do for fun?

Who are your family members and do you have any pets?

What are fun things you do with family?

What are your favorite things to do when you are alone?

What chores you do around the house?

When is bedtime?

When do you wake up?

Do you ever wake up at night?

Do you ever have nightmares?

Do you get bellyaches?

Do you get headaches or earaches?

Is it hard to see or read?

Do you get itchy?

Do you have allergies or sensitivities?

Does anything else hurt?

What do you eat for breakfast?

What do you eat for lunch?

What do you eat for dinner?

What do you eat for snacks?

What do you drink?

What foods do you wish you could eat more often?

What food do you wish you never had to eat again?

What do you want to learn about yourself?
