Children and Adolescents Self Report Form (18 and under only)

Client's name:_____Age_____Date_____ .

Name of person completing this form and relationship to client: _____

1. Briefly describe the problem that brought you here today:

Please check behaviors and symptoms that occur to you more often than you would like them to take place: List the onset and frequency of each checked behavior/symptom (i.e., 2 months ago, 3-4x wk)

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drugs dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other:
_____
_____

Psychiatric Treatment

2. Is client currently under the care of a therapist and/or psychiatrist for current or another problem? YES NO

Provider's name(s): _____

3. Has Client ever been treated in the past for psychiatric, substance abuse, emotional, or behavioral problems? YES No

If yes, when, where, and with whom?_____

Inpatient_____Outpatient_____

Did you find past treatment helpful? YES NO

4.Please list psychiatric medications and dosages given in past and results: _____

_____

5. Please list any current psychiatric medications and dosages prescribed to the client.

6. Has clients' family members currently or in the past been under the care of a therapist and/or psychiatrist? YES NO

MEDICAL PROBLEMS

7. Does the client have any current medical problems? YES NO

If yes, please list:_____

8. When was the last time the client was seen by a doctor? _____

9. Are immunizations up to date? YES NO

10. Is client currently taking medication for medical problems? YES NO

If yes please list medication, dosage, and purpose: _____

11. Are there any allergies and/or medication allergies? YES NO

If yes, please list: _____

12. Is there any history of head injury, seizures, loss of consciousness, or extended high fevers? YES NO

13 Would you like information from today's visit communicated to your

primary care provider or any other medical doctor? YES NO

If yes, list doctor's name, phone number, address:

Developmental Factors

14. Were there problems with pregnancy or delivery? YES NO If yes, please describe: _____

15. Was there any exposure to alcohol, tobacco, or other drugs during pregnancy? YES NO If yes, describe: _____

16. Were there any developmental problems (e.g. did patient walk/talk at appropriate ages)? YES NO If no, describe: _____

SUBSTANCE ABUSE

17. Does the client have/had problems with or treatment for drugs, alcohol, or other addictions? YES NO

18. Does the client currently attend support groups? YES NO

19. Please circle any of the following that the client have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, methamphetamines/speed, methadone, LSD, PCP, Ecstasy, inhalants.

If you circled any of the above substances, list the last time each substance was used & the average amount and frequency of use:

_____

_____

20. Does anyone in client's extended family have/had problems with drugs, alcohol, or other addictions? YES NO If so, relationships?

21. Have there been any problems/trouble related to substance abuse? YES NO

For ages 12 and up only – Please have adolescent complete the following:

1. Have you ever ridden in a car driven by you or someone else who was using alcohol/drugs? YES NO

2. Do you ever use alcohol or drugs to relax, feel better or fit in? YES NO

3. Do you ever use alcohol or drugs while you are alone? YES NO

4.Do you ever forget things you did while using drugs or alcohol? YES NO

5. Do your family or friends ever advise you to cut down on your drinking or drug use? YES NO

6. Have you gotten into trouble while you were using alcohol or drugs? YES NO

LEGAL ISSUES

22. Does client have/had problems with school or legal systems? YES NO

If yes, describe:_____

23. Is client currently on probation/parole? YES NO

24. Is a DFACS worker involved? YES NO

Educational/Work Concerns

25. Are grades.. ___average ____above average ___below average? Has there been a significant drop in grades recently? YES NO

26. Check any that apply: __learning disabilities __developmental disabilities __special education __alternative school __home school

27. List grade and name of school: _____

28. Is client experiencing difficulties in school? YES NO. If yes, please explain: _____

29 Are there any problems related to language/speech/hearing/vision? YES NO

30. Does the client have an IEP in effect? YES NO

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FAMILY/RELATIONSHIPS

31.Please list anyone who lives in the home, his/her age, and relationship

Relationship	Name	Age

32. List other extended family involved with client (include name, relationship and age):

_____

33. Are both biological Mother/Father in the home? YES NO

If no, please explain: ____ Divorced ___Separated __Single Parent Family ___Step Family _____ Other

34. Do client have contact with non custodial parent? YES NO

35. Does anyone in the family have psychiatric, emotional, substance abuse, or behavioral problems? YES NO

If so, please describe:_____

36. Is there any history of sexual and/or physical abuse? YES NO

37. Was client exposed to any domestic violence events? YES NO

38. Who is in client's support network (i.e. friends, family, religious organizations)?
_____
_____

39. List any spiritual/cultural/ethnic considerations that could impact therapy: _____

40. List client's strengths/resource and hobbies/interests: _____

41. Are there difficulties or concerns about how the client gets along with other people? YES NO

42. Does the client have any sexual orientation/gender issues or concerns? YES NO

43. Are there any other stressors or any additional information that would assist in understanding the current concern?
_____

44. Do you believe the client is suicidal at this time? YES NO

44. What are your goals for therapy? What would you like to see changed specifically? _____

_____

Signature of client or person completing this form:_____ Date: _____

Signature of therapist:_____ Date: _____