Schwartz
Therapy + Wellness, P.C.
small steps every day

Email

Print

SELF-REPORT HISTORY (Ages 13-17)

CLIENT NAME: _____ **AGE:** _____ **DATE:** _____

PLEASE TAKE YOUR TIME AND COMPLETE THE ENTIRE FORM. YOU MAY USE THE BACK IF NEEDED FOR MORE EXPLANATION.

Name of parent or guardian who brought you: _____

Was it your idea to come here? _____ If not, whose idea was it? _____

Why do you think you are coming here? _____

How do you feel about coming here? _____

What do you think your family will say the problem is? _____

What do you think the real problem is? _____

What do you like about yourself? _____

What do other people like about you? _____

What don't you like about yourself? _____

What don't other people know about you? _____

Name three things in your life that upset or bother you the most:

1. _____
2. _____
3. _____

INTERESTS/ ACTIVITIES (Please check off what you enjoy doing)

- ☐ Watch Television
- ☐ Movies/Videos
- ☐ Play Video Games
- ☐ Listen To Music
- ☐ Talk On The Phone
- ☐ Text Messaging
- ☐ Surfing The Internet
- ☐ Using Social Media
- ☐ Sing
- ☐ Dance
- ☐ Draw
- ☐ Build Things
- ☐ Write
- ☐ Read
- ☐ Play Instruments
- ☐ Be With Friends
- ☐ Be With Girlfriend
- ☐ Be With Boyfriend
- ☐ Be With Family
- ☐ Be By Myself
- ☐ Go Shopping
- ☐ Get Into Trouble
- ☐ Just About Anything
- ☐ Pray

Continued: INTERESTS/ ACTIVITIES (Please check off what you enjoy doing)

- ☐ Church, Temple, Or Other Religious Activities
- ☐ Sew, Knit, Embroider
- ☐ Scouting
- ☐ Eat
- ☐ Sleep
- ☐ Get Into Fights
- ☐ Exercise/Work Out
- ☐ School Sports
- ☐ Street Sports
- ☐ Cheer-Leading
- ☐ Other School Activities
- ☐ Drink
- ☐ Get High
- ☐ Diet
- ☐ Babysit
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

PERSONAL VIEWS

What else do you enjoy doing? _____

Are there activities that you would like to do but are afraid to do?

_____

Have you lost interest in activities that you normally enjoy? _____

What do you **hate** doing? _____

What makes you feel **happy**? _____

What makes you feel **angry**? _____

What makes you feel **sad**? _____

What makes you feel **scared**? _____

What do you **worry** about? _____

What keeps you from feeling happy? _____

What do you wish could be **different** in your life? _____

Do you ever think about running away or going to live with someone else? _____

Do you ever wish that you were dead or that you were never born? _____

Have you ever **thought** of seriously **hurting** or **killing** yourself? _____ When? _____

Have you ever **attempted** to seriously hurt or kill yourself? _____ When? _____

What did you do? _____

Have you ever felt that someone in your family wanted to get rid of you? _____ Who? _____

CONTINUED: PERSONAL VIEWS

Do you get bullied by other kids? _____ Rejected by other kids? _____

Have you ever thought of seriously hurting another person or an animal? _____

Have you ever actually hurt another person or an animal? _____

Do you like to set fires? _____ Are you in a gang? _____ Ever carry a weapon? _____

LEGAL

Have you ever gotten in trouble with the law? _____ How many time? _____

How did you get in trouble? _____Were you ever placed on probation? _____

COUNSELING

Have you ever seen a counselor for personal or family problems or school problems? _____

Where, when? _____

Why did you see a counselor? _____

SCHOOL

How do you feel about going to school? _____

Are you having any problems with your schoolwork? _____

How much **effort** do you make in your classes to get good grades? _____

How much **effort** do you make on homework to get good grades? _____

Do you skip many classes? _____ What do you do when you skip classes? _____

Are you expecting to pass all of your classes this semester? _____

Do you get along with your teachers? _____ With your classmates? _____

Are you having another problem in school? _____

EMPLOYMENT

Where do you work? _____ How many hours per week? _____

RELIGIOUS/ SPIRITUAL

Do you have religious, or spiritual beliefs? If so briefly explain what are they? _____

Do you go to a religious institution? _____

Do you pray? _____ Do you have any religious concerns? _____

SEX

Are you sexually active? _____ Do you use protection? _____

When was your first sexual experience? _____

Do you have any sexual problems or worries? _____

DRINKING/ DRUG USAGE

Do you smoke cigarettes/ use e-cigarettes or vape? _____

Since what age? _____ How many a day? _____

Did you ever get high? _____ At what age? _____

What did you get high on? _____

What do you drink or use now? _____ How many times a day? _____

How many have you drank or used in the last 2 days? _____

If you drink or use drugs do your parents know? _____

What do they think, or what would they think about you drinking or getting high? _____

Do you think you need help with your drinking or drug usage? _____

FAMILY/ RESPONSIBILITIES/ RELATIONSHIPS

Who are you closest to in your family? _____

Who don't you get along with in your family? _____

Why don't you get along? _____

What chores do you have to do at home? _____

Do you do them willingly? _____

Do you obey the rules at home? _____ Do you think the rules are fair? _____

What do your parents do when you break the rules or neglect your chores? _____

Are you having any problems with your family? _____

Are you having any boyfriend or girlfriend problems? _____

ADDITIONAL INFORMATION

Do you have anything else to share at this time? If so, please use the space provided to provide additional information to your therapist: _____

_____

_____