Dependent Child/Adolescent Self Report

The following questions are intended to gather information about your health. This information is voluntary, and may aid in the identification of physical disorders or conditions that may be relevant to the mental health services provided to you.

Counselor: ______________________________ Date: ____________________

Client Name:_____________________________ Social Security #: ___________________

Birth Date: ____________________ Address: _____________________________________

City:_________________________ State/Zip: _____________________

Home Phone: ________________________ Cell Phone: ____________________________

Residential Parent(s)/Guardian(s): ____

Cell Phone: ______________________________ Work Phone: ________________________

Their employer: _________________________ May we contact them at work?: Yes No

Non-Custodial Parent or Guardian (if applicable): ________________________________

Address/Phone # ____

Employer(s) and Phone #'s ____
May we contact them at work? yes no

Please list all persons currently living in the client's household excluding client and residential parent(s) listed above.

Last name	First Name	Relationship w/Client	Sex	Birth Date	Health

Presenting Concern(s) What issue(s) bring you in for counseling?

Client's Present Physical Condition

Height______ Weight______ Appetite_____

(Please Check)	Good	Fair	Poor
General Health:			
Vision:			
Hearing:			

Effects of earlier operations or hospital stays ______________________________

____

Any bowel or urinary malfunctions ______________________________

Any use of: ______Alcohol _____Drugs ______Tobacco _____Caffeine

Allergies:____

Do you have any significant physical problems __________ Please explain ___________

____

Approximately how long ago were you examined by your personal physician?

____

Physician Name & Phone Number: ______________________________

____

Client's Mental Health

Have you had any prior mental health counseling, evaluation, or treatment? ____yes ___no

List and describe:

Agency Name	Address	Phone	Therapist	Dates

Have you ever been hospitalized for mental health treatment? ____yes ___no

Describe:____

____

Have you ever tried to commit suicide? ___yes _____no When?_______________

Do you have any suicidal thoughts at this time? _________ Yes ____________ No

Please list any medications you are currently taking:

Medication	Dosage/Frequency	Prescribing Doctor

School Life

Client's School ______________________________ Phone # _______________
Grade level ___ Counselor ____________________ Teacher ____________________
Recent Evaluative Testing Completed ____
____

Three things you enjoy about school
1. ____________________ 2. ____________________ 3. ____________________

Three things that irritate you about school
1. ____________________ 2. ____________________ 3. ____________________

Do you have a job? With whom? ______________________________________

What do you hope to be or do after you are finished with school?

Social Life

Who would you consider to be your best friend, and why?

What types of people are you comfortable with?

Would you consider yourself more of a leader or more of a follower?

What is your attitude toward social functions?

Girlfriend/Boyfriend? (if applicable) Name ____________________ Age ________

Enjoyment / Recreation / Relaxation

WHAT'S FUN?!! List the things you most enjoy doing with your leisure time:
____
____

Unconscious Life

Sleep Well? ________ How Long? ________ Aided by drugs? ___________
Nightmares and/or recurring dreams? ______________________________
Unconscious habits? ____
Fears with unknown origins? ______________________________________
Obsessive/Compulsive acts or thoughts? (behaviors you repeat over again and again or keep thinking about the same thing all the time?) ______________________________
____

Emotional Relationships (How is your relationship...)

Between you and your mom? ______________________________________
Between you and your dad? ______________________________________
Between you and your step-mom? __________________________________
Between you and your step-dad? ___________________________________

Between you and your brothers/sisters? ______________________________
Between you and another important person to you? ______________________
Your most important relationship is you and ____________________ .
What makes it so important? ______________________________

The best thing that ever happened in your life? ______________________
____
The worst thing? ____
If you could change anything about your life, what would it be? ______________
____

Optional Section

Please fill out the information below only if it is age appropriate and/or applicable for you or your child.

Sexual Life (If older than age 11)

When was the client initially informed about sex? ________By whom? __________
How?____

How does the client feel about sex? ______________________________

Is the client currently sexually active? ______________________________

Spiritual Life

What place does religion apply in your home today? ______________________
____
What are your beliefs about God? ______________________________
____
Are you a practicing Christian? ___________ (If no, please disregard the next section)

Christian Belief System

When and how did your Christian life begin? ______________________
____
Do you pray regularly? ______________
Read the Bible regularly? __________
Are you fearful of going to hell? ________
Of not being forgiven? ____________
Do you have favorite Bible verses? Which and Why? ______________________
____
If you could ask God for 3 things, what would they be?
____
____
What would you consider the worst sin a person could commit, and why?
____
____

What would you consider the most Christian deed a person could perform, and why?

____

____

Who is the most influential Christian in your life today and why?

____

What would you consider to be the best things about being a Christian?

____

The worst things? ____

____

How do you feel about your church experience?

____