Missouri Ozarks Community Health

ADOLESCENT SELF-REPORT
(AGES 13-17)

Please complete this form as well as you can. It will help your counselor to understand – in your own words – why you are here and what difficulties you may be having. Take your time, and just do your best. If you have any questions, your counselor will go over the form with you later.

Today’s Date: _____________________

Your Name: ________________________ Age: _____ Grade: ___________

Name of Parent or Guardian who brought you: _______________________

Was it your idea to come? ______ If not, whose idea was it? _______________________

Why do you think you are coming here? ________________________________

_____________________________________________________________________

What do you think they will say the problem is? _________________________

What do you think the problem is? ________________________________

Name three things in your life that upset or bother you the most:
1. ___________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________

Have you ever seen a counselor outside of school? ______ When: ______________

Why were you seeing the counselor? ________________________________

Was it helpful? _____ If not, why not? _______________________________

Have you ever seen a counselor in school? ______________________________

Was it helpful? _____ If not, why not? _______________________________

What do you like to do (circle the number for each thing that you enjoy):

1. Be with my friends 11. Be with boyfriend or girlfriend 21. Get high
2. Watch television 12. Stay to myself 22. Drink
3. Listen to music 13. Eat 23. Play instrument
5. Play sports or exercise 15. Nothing 25. Skate
7. Read 17. Talk on the telephone 27. Go shopping
10. Get into trouble 20. Do things with family 30. _______________________

What else do you enjoy? ____________________________________________
Are there things you used to enjoy but you don’t enjoy now? 

Name some things: 

Name some things that you’d like to do but are afraid to do: 

What do you hate doing: 

What chores or responsibilities do you have at home? 

How well do you do in school? 

Favorite classes: 

Classes you don’t like: 

Are you doing as well as you can in school? 

If not, why not? 

Do you have a job? ______ Where: __________________ Total hours a week: 

Do you have spiritual beliefs? _____ Pray? _____ Go to Church? 

Have you ever been in trouble with the law? _____ How many times? 

How did you get in trouble with the law? 

Have you ever been on Probation? _____ When: 

Have you ever thought of running away or actually ran away? _____ If yes, when/why: 

Have you ever wished you were dead? _____ When: 
What made you feel that way? 

Did you ever have a real plan to hurt yourself? 

Did you ever actually hurt yourself on purpose? _____ When: 
What did you do? 

Have you felt like dying or hurting yourself in the last few weeks? _____ If yes, why: 

Do you ever think of hurting other people or animals? 

Have you ever actually hurt other people or animals? 
What did you do?
Have you ever had sex? ______  Having sex now? ______  Do you use protection? ______

Do you smoke cigarettes? ______  How many a day? ____________________________

Have you ever gotten high? ______  When: ________________________________

Do you drink or get high now? ______  How many days a week? ____________________________

What do you get high on? ________________________________

What did you get high on in the past? ________________________________

What do your parents think about you getting high? ________________________________

Name some things you like about yourself: ________________________________

Name some things you don’t like about yourself: ________________________________

Name some things you worry about: ________________________________

What makes you feel happy? ________________________________

What makes you feel sad? ________________________________

What makes you feel angry? ________________________________

Who are you closest to in your family? ________________________________

Who don’t you get along with in your family? ________________________________

Why don’t you get along? ________________________________

Therapist Signature: ________________________________  Date: __________________