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

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: ________________________