ADOLESCENT SELF-REPORT
(AGES 13-17)

Please complete this form as well as you can. It will help me to understand – in your own words – why you are here and what difficulties you might be having. If you have any questions, I will go over the form with you in your session.

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? _____

_____

How do you feel about 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. _____

Please review the following list and circle those that you feel describes you:

1. Speech difficulties
2. Nervous habits/behavior
3. Frequent headaches
4. Frequent stomach-aches
5. Difficulty sleeping
6. Lacks guilt/remorse
7. Difficulty making friends
8. Difficulty keeping friends
9. Little interest in friends
10. Little interest in activities
11. Disrespectful/argumentative
12. Doesn't complete schoolwork
13. Acts before thinking
14. Short attention-span
15. Unable to sit still
16. Overactive
17. Underactive
18. Sucks thumb
19. Bangs head
20. Grinds teeth
21. Nightmares
22. Angry
23. Hurts animals
24. Sets fires
25. Steals
26. Lies a lot
27. Too serious
28. Fights a lot
29. Clowns a lot
30. Acts spoiled
31. Temper tantrums
32. In own world
33. Afraid/fearful
34. Accident-prone
35. Seems insecure
36. Sad/depressed
37. Worries a lot
38. Cries frequently
39. Mentally slow
40. Interested in sex
41. Looks "high" often
42. Separation problems
43. Imaginary friends
44. Ignores rules
45. Defies authority

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
2. Watch television
3. Listen to music
4. Sing or dance
5. Play sports or exercise
6. Sleep a lot
7. Read
8. Write
9. Draw
10. Get into trouble
11. Be with boyfriend or girlfriend
12. Stay to myself
13. Eat
14. Diet
15. Nothing
16. Just about anything
17. Talk on the telephone
18. Baby-sit
19. Build or fix things
20. Do things with family
21. Get high
22. Drink
23. Play instrument
24. Play video games
25. Skate
26. Roller blade
27. Go shopping
28. Go to school
29. Prayer/Church
30. _____

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 _____

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 get along with classmates? _____

If not, why not? _____

Have you ever been bullied or rejected by other kids? _____

Do you get along with your teachers? _____

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, 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? _____

Do you have a boy/girlfriend?_____How long have you been dating?_____

Are you having any boy/girlfriend problems?_____

Have you ever had sex? _____ Having sex now? _____ Do you use protection?_____

Do you smoke cigarettes? _____ Since what age?_____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? _____

_____

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

Are you having any problems with your family? _____

Therapist Signature: _____ Date: _____

Client Signature: _____ Date: _____

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