

The Power in Parenting

ADOLESCENT SELF-REPORT HISTORY

(Ages 13-17)

Your Name: _____ Age: _____ Date: _____

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 like about you? _____

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

1) _____

2) _____

3) _____

INTERESTS/ ACTIVITIES (What do you enjoy doing?) :

<input type="checkbox"/> Watch television	<input type="checkbox"/> Be with friends	<input type="checkbox"/> Eat
<input type="checkbox"/> Movies/ videos	<input type="checkbox"/> Be with girlfriend	<input type="checkbox"/> Sleep
<input type="checkbox"/> Play video games	<input type="checkbox"/> Be with boyfriend	<input type="checkbox"/> Get into fights
<input type="checkbox"/> Listen to music	<input type="checkbox"/> Be with family	<input type="checkbox"/> Exercise/ work out
<input type="checkbox"/> Talk on phone	<input type="checkbox"/> Be by myself	<input type="checkbox"/> School sports
<input type="checkbox"/> Sing	<input type="checkbox"/> Go shopping	<input type="checkbox"/> Street sports
<input type="checkbox"/> Dance	<input type="checkbox"/> Get into trouble	<input type="checkbox"/> Cheer-leading
<input type="checkbox"/> Draw	<input type="checkbox"/> Just about anything	<input type="checkbox"/> Other school activities
<input type="checkbox"/> Build things	<input type="checkbox"/> Pray	<input type="checkbox"/> Drink
<input type="checkbox"/> Write	<input type="checkbox"/> Church activities	<input type="checkbox"/> Get high
<input type="checkbox"/> Read	<input type="checkbox"/> Sew, knit, embroider	<input type="checkbox"/> Diet
<input type="checkbox"/> Play instrument	<input type="checkbox"/> Scouting	<input type="checkbox"/> Baby-sit

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? _____

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 animal? _____

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

LEGAL: Have you ever gotten into trouble with the law? _____ How many times? _____

How did you get into 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 and on your homework to get good grades? _____

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

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

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

Are you having any other problems in school? _____

EMPLOYMENT: Where do you work? _____ How many hours a week? _____

RELIGIOUS/ SPIRITUAL:

Do you have religious or spiritual beliefs? _____ Do you go to church or synagogue? _____ 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? _____ 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 days a week? _____
How much (amount) do you drink or use now? _____
How much have you drunk 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? _____

Clinician's Signature Credentials Date