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) _____

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

☐ Watch television	☐ Be with friends	☐ Eat
☐ Movies/ videos	☐ Be with girlfriend	☐ Sleep
☐ Play video games	☐ Be with boyfriend	☐ Get into fights
☐ Listen to music	☐ Be with family	☐ Exercise/ work out
☐ Talk on phone	☐ Be by myself	☐ School sports
☐ Sing	☐ Go shopping	☐ Street sports
☐ Dance	☐ Get into trouble	☐ Cheer-leading
☐ Draw	☐ Just about anything	☐ Other school activities
☐ Build things	☐ Pray	☐ Drink
☐ Write	☐ Church activities	☐ Get high
☐ Read	☐ Sew, knit, embroider	☐ Diet
☐ Play instrument	☐ Scouting	☐ 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 your classes this semester? _____

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

Are you having any other problems in school? _____

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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