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Self-Report Form

Client Name: ______________________________________Date:_______________________

DOB: ____ Age: ______________

Please check all of the behavior and symptoms that you consider currently problematic:

	Distractibility		Hyperactivity		Impulsivity		Poor Memory		Confusion
	Seasonal Mood Changes		Sadness		Depression		Hopelessness		Thoughts of Death
	Self-Harm		Loneliness		Low Self-Worth		Guilt/Shame		Change in Appetite
	Lack of Motivation		Withdrawal from People		Panic Attacks		Fear of Being Away from Home		Social Discomfort/Anxiety
	Compulsive Behavior		Aggression/Fights		Frequent Arguments		Homicidal Thoughts		Flashbacks
	Hearing Voices		Suspicion/Paranoia		Racing Thoughts		Excessive Energy		Sleep Problems
	Eating Problems		Nightmares		Computer Addiction		Problems with Pornography		Parenting Problems
	Relationship Problems		Work/School Problems		Alcohol/Drug Use		Boredom		Fatigue
	Irritability/Anger		Loss of Pleasure		Anxiety/ Worry Thought		Visual Hallucinations		Crying Spells
	Obsessive Thoughts		Wide Mood Swings		Gambling Problems		Sexual Problems		Other:___________

Additional Symptoms or Problems:

Previous or Current Diagnosis:	

Please check all the areas that your problems are affecting:

	Hygiene		**Self-Esteem**		**Legal Matters**		**Recreation Activities**
	Relationships		**Housing**		**Physical Health**		**Daily Tasks**
	Work/School		**Sexual Activity**		**Finances**		**Other:**

Client Initials: ______________

Current /Previous Treatment

	Provider Name	Dates Seen	Progress in Treatment
Current/Previous Therapist			
Current/Previous Prescriber			
Current/Previous Treatment Programs			
Current/Previous Community Resources/Meetings			

Previous/Current Psychiatric Medications:____

Have you ever been hospitalized for psychiatric reasons? Yes No

Explain the reason/dates of hospitalization:_______________________________________

High Risk Behaviors

Suicide:

Current thoughts of ending my life:		None		Mild		Moderate		Strong

Attempts Made Date/Age	What caused it?	How did you attempt? What did you do?	Treatment Received After Attempt

Self Harm:

Do you currently engage in self-harm behaviors?	Circle One: Yes No
What type of self-harm behavior?	**Describe:**

Client Initials: _______________

Have you engaged in self-harm behavior in the past?	**Circle One: Yes No**
What type of self-harm behavior?	**Describe:**
What ages did you engage in the behavior?	**List here:**

Aggressive Behavior:

Do you have urges to or thoughts about hurting others?	**Circle one: Yes No**
Do you have history of aggressive behaviors?	**Circle one: Yes No**

Alcohol/Drug Use

Including yourself, is there a history of any or all of the following in your family? (Circle Every Answer That Applies)

Alcoholism Substance Abuse Physical/Sexual Abuse Mental Illness

Eating Disorders Suicide or Self Harm Homicide or Violence Legal Problems

Child Abuse Elder Abuse Domestic Violence Anger Control

Other: ______________________________

Have there been any recent deaths, births, or serious illnesses in your family? (Circle) Yes No

If Yes, please explain. ____

How many times per week do you drink alcohol? __________________

How many drinks do you consume each time you drink? _____________

How many times per week do you use recreational drugs? ____________

 Client Initials: ______________

Which recreational drugs do you use? (Circle Every Answer That Applies)

Marijuana Cocaine Crack Crank Acid Heroin

Sniff Glue Other Uppers Other Downers Other Hallucinates

Work/School History

High School	Circle One	
Did you graduate?	Yes No	If yes, what year?
College/University		
Did you graduate?	Yes No	If yes, what year? Degree?
Please list current/previous employment:		

Family/Relationship History

Parent's Marriage:	Circle One: Married Separated Divorced, at age:______ Remarried, at age:______ Single/Unmarried Other:_________
Spiritual/Religious Background:	
Current spiritual/religious practice:	
Early Childhood Experiences (did you feel loved, heard, understood, attuned to?)	
Trauma/Abuse History:	Circle all that apply: None Physical Abuse Emotional Abuse Sexual Abuse Neglect Other trauma:__________

Client Initials: ______________

Relationship	Age	How would you describe this person?	Quality of relationship?	Mental Health Problems?
Mother				
Father				
Stepmother				
Stepfather				
Brother				
Brother				
Sister				
Sister				
Other:				
Children (list)				

Social Network (Circle all that apply)

Family	Friends	Co-Workers	Students	Community Groups
Support or Self-Help Groups	Religious/Spiritual Groups	Neighbors	Other:	

Please describe your strengths, skills, and talents (in space below).

Please describe what you are hoping to get out of therapy(in space below).

Client Initials: _______________