SELF REPORT

Date:_____

Name of Patient:_____
Age:_____
Name of person completing form if not the
Patient:_____ (relationship):_____

Briefly describe the problems that brought you here
today:_____
_____
_____
_____

Check any issues you are having difficulty with.

ADHD
- ☐ hyperactive
- ☐ impulsive
- ☐ under achievement
- ☐ non-compliant
- ☐ inattentive
- ☐ poor concentration
- ☐ disorganized

Depression
- ☐ sad
- ☐ sleep problems
- ☐ negative thinking
- ☐ poor concentration
- ☐ hopeless/worthless
- ☐ mood swings
- ☐ guilt

Anxiety
- ☐ excessive worry
- ☐ panic attacks
- ☐ irrational fear
- ☐ obsessions
- ☐ social isolation
- ☐ phobias
- ☐ compulsive

Relationship
- ☐ marital/significant other
- ☐ parenting
- ☐ difficulty with friends
- ☐ work/school problems
- ☐ personal growth
- ☐ grief/loss
- ☐ bullying/teasing

Anger
- ☐ short-fused
- ☐ temper tantrums
- ☐ impulse control
- ☐ violent/assaultive
- ☐ runaway risk
- ☐ fighting
- ☐ irritable
- ☐ oppositional

Addictions
- ☐ alcohol
- ☐ drugs
- ☐ gambling
- ☐ relationships/sex
- ☐ eating disorders
- ☐ cyber/internet
- ☐ spending

Abuse
- ☐ physical
- ☐ emotional
- ☐ domestic violence
- ☐ rape
- ☐ sexual
- ☐ dissociative

Other
- ☐ agitated
- ☐ mania
- ☐ paranoia
- ☐ delusions
- ☐ tics/tourettes
- ☐ cutting behavior
- ☐ appetite changes
- ☐ nightmares/flashbacks
- ☐ eating disorders

Comments

_____
_____
_____

Are you now or have you ever had thoughts of hurting yourself or someone else? **yes** **no**

Please explain:_____

Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? **yes** **no**

If yes, when, where, and with whom? _____

Inpatient _____ Outpatient _____

Did you find past treatment helpful? **yes** **no**

If yes, how?_____

If no, why not?_____

Please list any medications given in the past _____

_____

Are you currently under the care of a psychiatrist or therapist for your current problem? yes no

Are you currently taking any medications for psychiatric problems? yes no

If yes, please list:_____

_____

Psychological Testing – Please name person or agency performing test, location and dates:

_____

Do you have difficulties or concerns about how you get along with other people? yes no

Are you having difficulties with spiritual or religious matters? yes no

Do you have any sexual orientation/gender issues or concerns? yes no

On a 1-10 scale (poor-great): How would you rate your marriage? _____

How would you rate your job? ___ How would you rate school? ____

MEDICAL PROBLEMS

Personal Physician: _____Phone_____

Date of last physical exam ___/____/_____ Results of examination _____

Do you have any current medical problems? **yes** **no**
If yes, please list:_____

When was the last time you were seen by a doctor? _____

Are you taking medication for medical problems? **yes** **no**
If yes, please list medication, dosage, and purpose:_____

_____

Do you have any allergies and/or medication allergies? **yes** **no**
If yes, please list:_____

Do you have a history of head injury, seizures or loss of consciousness? **yes** **no**
Please explain:_____
(Women only) Are you pregnant? **yes** **no** Are you on birth control ?: type_____

Do you have pain management issues? **yes** **no**

SUBSTANCE ABUSE

Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex)? **yes** **no**

Do you currently attend support groups? **yes** **no**

Circle the following you have used in the past 30 days:
tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants

Have you experienced withdrawal symptoms? **yes** **no**

If yes, circle all that apply: headaches, nausea, vomiting, tremors, seeing things, hearing things

Have you ever had a DUI? **yes** **no**

LEGAL ISSUES

Do you have current legal problems? **yes** **no**
If yes, describe:_____

_____

Are you currently on probation/parole? **yes** **no**

Do you have a DFACS worker? **yes** **no**

EMPLOYMENT / EDUCATION

Circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired.

Are you currently on leave from work or seeking medical leave/disability? **yes** **no**

If yes, do you have paperwork that needs to be completed? **yes** **no**

If yes, please give clinician paperwork at beginning of session!

Circle educational background: current student, did not complete high school, GED, some college, graduated college, advanced degree

Did you experience difficulties in school? **yes** **no**

FAMILY / RELATIONSHIPS

Please list anyone who lives in your home, his/her age, and relationship.

_____

_____

Does anyone in your immediate family have psychiatric, emotional, substance abuse, or behavioral problems? **Yes** **No**

If yes, describe: _____

_____

Is your immediate family supportive of you seeking treatment? **yes** **no**

Do you have any domestic violence history or current issues? **yes** **no**

Do you have any history of sexual and/or physical abuse? **yes** **no**

Is your support network (circle one) Good Fair Poor (i.e., friends, family, neighbors, religious organizations)

Please list: _____

What are your hobbies/interests?_____

TREATMENT ACCESS/MOBILITY

Are there any financial concerns that would affect your ability to access treatment? **yes** **no**

Do you have access to transportation? **yes** **no**

Do you have any disabilities, special needs, or restrictions that may impact your treatment? **yes** **no**

Based on the information you provided in this self-report, what would you like to see changed? _____

_____

_____

_____

_____

In your opinion, what could block or prevent that change? _____

_____

_____

_____

_____

_____ _____

Patient (or person completing this form) signature Date

Thank you for completing this questionnaire.