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Self-Report Form

Client Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sexual Orientation: _____

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/Suicide		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		Nightmares		Eating Problems
	Computer Addiction		Problems with Pornography		Parenting Problems
	Relationship Problems		Work/School Problems		Alcohol/Drug Use
	Boredom		Fatigue		Irritability/Anger
	Loss of Pleasure		Anxiety/Worry Thoughts		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:

Current Treatment

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

History of Problems

Time Period	Highlights of Problem
Childhood	
Adolescence	

Previous Treatment and Outcome

Provider/Program	Dates Seen	Did it help? What did you like? Dislike?

Hospitalizations

Hospital	Dates	Reason for 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 the Attempt

Self-Harm:

Do you currently engage in self-harm behaviors?		Yes				No		
What type of self-harm behavior?		Cutting		Burning		Scratching		Other:
What usually causes urges to self-harm?								
Have you engaged in self-harm behaviors in the past?		Yes				No		
What type of self-harm behaviors?		Cutting		Burning		Scratching		Other:
Ages you engaged in this self-harm behavior:								

Aggressive Behavior:

Do you have urges to, or thoughts about, hurting others?		Yes		No
Do you have a history of aggressive behaviors?		Yes		No
What causes aggressive behaviors? Please list details.				

Legal History

	None		On Probation		Convicted of Felony		Involved in Custody Case
Number of Arrests:			Involved in Divorce		Convicted of Misdemeanor		Legal Charges

Alcohol/Drug Use

Currently use:		Alcohol		Marijuana		Cocaine		Methamphetamines		Heroin
		Inhalents		LSD		Steroids		Prescriptions – List Type:		Ecstasy
History of Use:										
Previous Treatment		Outpatient Treatment				Inpatient Treatment				Intensive Outpatient Trmt
Family History of Alcohol or Drugs		Father				Brothers/Sisters				Aunts/Uncles
		Mother				Grandparents				Other:

Have you had withdrawal symptoms?		Yes	If Yes, please describe:
		No	

Have you had problems with work/school, relationships, health, the law, etc. due to substance use?		Yes	If Yes, please describe:
		No	

Work/School History

High School						
Did you graduate?		Yes		No		If Yes, what year?
College/University						
Did you graduate?		Yes		No		If Yes, what year?
Degree						
Work/Job History *(Types of jobs. Why did you leave jobs? How long did you stay in jobs?)*						

Family/Relationship History

Birth Place:								
Parents' Marriage		Married		Separated		Divorced, at age:		
		Single/Unmarried		Other:		Remarried, at age:		
Spiritual/Religious Background								
Current Spiritual/Religious Practice								
Cultural Background								
Early Childhood Experiences (Did you feel loved, heard, understood, attuned to?)								
Trauma/Abuse History		Emotional Abuse		Physical Abuse		Neglect		
		Sexual Abuse		Other Trauma:				

Relationship	Age	How would you describe this person?	Quality of relationship?	Mental health problems?
Mother				
Father				
Stepmother				
Stepfather				
Brother:				
Brother:				
Sister:				
Sister:				
Other:				
Spouse/Partner				
Children (list)				

Social Network

Please check all current social supports.

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

Please describe your strengths, skills, and talents.

_____
_____
_____
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_____
_____
_____

Please describe what you are hoping to get out of therapy.

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