First Step

Counseling &
Educational Services, LLC

ADOLESCENT SELF-REPORT HISTORY
(Ages 13 – 17)

Case #: _____

Your Name: _____ Age: _____ Date: _____

Name of parent/guardian who brought you: _____

Was it your idea to come here? _____ If not, whose idea was it? _____

Why do you think you are here? _____

How do you feel about being here? _____

What do you think your family will say is the problem? _____

What do you think is the real problem? _____

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

1. _____

2. _____

3. _____

INTERESTS/ACTIVITIES: What do you enjoy doing? Please check all boxes:

☐ Watch television
☐ Movies/Videos
☐ Play video games
☐ Listen to music
☐ Talk on phone
☐ Sing
☐ Dance
☐ Draw
☐ Build things
☐ Write
☐ Read
☐ Play instrument
☐ Be with friends
☐ Be with boyfriend
☐ Be with girlfriend
☐ Be with family
☐ Be alone
☐ Go shopping
☐ Get into trouble
☐ Pray
☐ Church activities
☐ Sew, Knit, Embroider
☐ Scouting
☐ Eat
☐ Sleep
☐ Get into fights
☐ Exercise/Work out
☐ School sports
☐ Street sports
☐ Cheerleading
☐ Other school activities
☐ Drink
☐ Get high
☐ Diet
☐ 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? _____

INTERESTS/ACTIVITIES: (Cont.)

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 a family member wanted to get rid of you? _____ Who? _____

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

LEGAL HISTORY:

Have you ever been in trouble with the law? _____ How many times? _____

How did you get into trouble? _____ Have you ever been on probation? _____

EMPLOYMENT: Do you work? ☐ Yes ☐ No

If so, where? _____ How many hours per week? _____

EDUCATION: Name of School: _____Grade: _____

School Address: _____ Phone: _____

Teacher: _____ Counselor: _____

Is child in any special classes? _____ Since what grade? _____

Does child have any learning disabilities? _____

Has child repeated any grades? _____ Which grade(s)? _____

Describe child's attendance: _____

Describe effort/attitude toward school: _____

Describe child's behavior in school: _____

Describe academic performance: _____

When did school behavior or academic performance change? _____

Education of each parent or guardian: _____

_____

ETHNIC/CULTURAL BACKGROUND (CHILD'S): _____

RELIGIOUS/SPIRITUAL BACKGROUND (CHILD'S): _____

SEXUAL/GENDER ISSUES (Describe any sexual or gender concerns you have about child):

_____

PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:

OUTPATIENT: Has the child seen a therapist or counselor for personal or family problems or alcohol/drug treatment? _____

If yes, when? _____

Reason: _____

INPATIENT: Has the child been in a hospital/residential treatment for personal problems or alcohol/drug problems? _____

If yes, when? _____ Name of Facility: _____

Reason: _____

Were any of the child's treatment experiences helpful? _____

What medications was child prescribed for emotional or behavioral problems? _____

Which of those medications were helpful? _____

List any of child's relatives (parents, grandparents, aunts, uncles, cousins, brothers, sisters) who have been hospitalized for personal or substance abuse problems:

Who, when, where? _____

_____

PHYSICAL HEALTH: Child's Physician: _____

Physician's Address: _____ Phone: _____

Date child last saw physician: _____ Reason: _____

Results of Physician visit/tests: _____

Medications child is taking: _____

Are immunizations up to date? _____

Child's Height: _____ Weight: _____ Appetite: _____ Recent weight gain or loss? _____

Does child overeat? _____ Binge _____ Purge? _____ Energy/activity level: _____

Food or medication allergies: _____

PHYSICAL HEALTH: (Cont.)

If child has had any serious illnesses, injuries, surgeries or medical hospitalizations, please explain:

_____

_____

DEVELOPMENTAL HISTORY: Was your pregnancy desired? _____ Length of term: _____

Problems/complications during pregnancy: _____

Did mother smoke, drink, use drugs during pregnancy? _____

Problems/complications during delivery: _____

Explain if mother and child were separated after birth: _____

Other mother/child separations: _____

Describe child as an infant/toddler (happy, fussy, overactive, withdrawn, etc.): _____

Age child sat up: _____ Took steps: _____ Spoke words: _____ Spoke in sentences: _____

Age child was weaned: _____ Began feeding self: _____

Age child was toilet-trained (Daytime) _____ Night-time _____ Problem Now: _____

Age child dressed self: _____ Age Child tied own shoelaces: _____ Age child rode 2-wheel bike: _____

FAMILY RELATIONSHIPS: How do you get along with child? _____

How does spouse/partner get along with child? _____

If one or both of child's parents are out of the home, describe each one's current relationship with child: _____

Father: _____ Mother: _____

How does child get along with brothers and sisters? _____

RULES/RESPONSIBILITIES/RELATIONSHIPS:

How does child deal with rules, responsibilities, chores? _____

Does child obey curfew? _____ Has child threatened/attempted to run away or stay out all night? _____

How do you deal with child's misbehavior? _____

Do you or your spouse/partner believe in physical discipline? _____

Has the family ever been involved with Child Protective Services? _____

Are there any situations at home that might influence child's behavior? _____

DRINKING/DRUG USAGE: IF CHILD *DRINKS* OR USES *DRUGS*, PLEASE ALSO COMPLETE THE NEXT PAGE.

Type of Drug	Age of 1st Use	At what age was child using regularly	Average number of days used each week	Usual amount used on an average day	Number of days used in the past 30 days	Amount used in the last 48 hours	Date you last used
Beer, Wine							
Cigarettes							
Cocaine Powder							
Codeine: Tylenol 3, 4, Other							
Coffee, Cola, Caffeine Pills							
Crack Cocaine							
Heroin (Shoot IV)							
Heroin (Snort)							
Liquor							
Methadone							
Pain Pills: Type:							
Muscle relaxers: Soma, Flexeril, Other:							
Tranquilizer: Valium, Librium, Other:							
Inhalents, Glue, Poppers, Aerosols							
PCP, LSD, Mescaline							
Meth-amphetamine, Speed, Ritalin, Adderall							
Phenobarbital, Sleeping Pills							
Steroids							

Over-the-Counter Drug:							
Other:							
What are your drugs of preference? 1. 2.							

Therapist/Credentials: _____ Date: _____

Consultant/Psychiatrist Signature: _____ Date: _____