

Name: _____ Age _____ Date: _____

SELF-REPORT FORM Age 11-17

In the last 2 weeks, indicate how much you were distressed/bothered by:

	Extremely	Highly	Moderate	Slight	Not at all
Feeling depressed/blue:	4	3	2	1	0
For how many ___yrs ___months ___weeks ___days?					
Crying Spells:	4	3	2	1	0
For how many ___yrs ___months ___weeks ___days?					
Feeling anxious/tense/panic:	4	3	2	1	0
For how many ___yrs ___months ___weeks ___days?					
Difficulties falling or staying asleep:	4	3	2	1	0
For how many ___yrs ___months ___weeks ___days?					
Abnormally elevated mood:	4	3	2	1	0
Relationships with:					
My friends:	4	3	2	1	0
My parents:	4	3	2	1	0
Significant other:	4	3	2	1	0
Others_____:	4	3	2	1	0
Family issues:	4	3	2	1	0
Grief/loss issues:	4	3	2	1	0
Abuse issues: ___Physical					
___sexual ___emotional	4	3	2	1	0
Memories of past experiences affecting my current life:	4	3	2	1	0
Lack of assertiveness/being taken advantage of:	4	3	2	1	0
Aggressive/violent behavior toward others:	4	3	2	1	0

Distressed/bothered by: Extremely Highly Moderate Slight Not at all

Distressed/bothered by:	Extremely	Highly	Moderate	Slight	Not at all
Being bullied:	4	3	2	1	0
Anger/irritability/negativity:	4	3	2	1	0
Making and keeping friends:	4	3	2	1	0
Getting stuff done:	4	3	2	1	0
Thoughts of hurting myself:	4	3	2	1	0
Self harm behaviors:	4	3	2	1	0
Thoughts of hurting others:	4	3	2	1	0
School issues:	4	3	2	1	0
Work issues, if applicable:	4	3	2	1	0
Financial difficulties:	4	3	2	1	0
Legal issues:	4	3	2	1	0
My physical health:	4	3	2	1	0
Issues related to Sexuality:	4	3	2	1	0
Issues related to gender identity:	4	3	2	1	0
Chemical (drugs/alcohol) use:	4	3	2	1	0
Addictive/Compulsive behavior:	4	3	2	1	0
Issues with food/eating: __Bingeing, __Purging, __restricting food intake	4	3	2	1	0
Unwanted/Intrusive/Obsessive Thoughts:	4	3	2	1	0

Distressed/bothered by: **Extremely** **Highly** **Moderate** **Slight** **Not at all**

Repetitive behaviors or mental acts in response to obsessive thoughts: 4 3 2 1 0

Feeling lonely: 4 3 2 1 0

Difficulty identifying and expressing feelings: 4 3 2 1 0

Poor self esteem: 4 3 2 1 0

Check if present:

Problems with: memory ___ concentration ___ fatigue ___ indecisiveness ___
motivation ___ frequent headaches ___ caffeine use ___ how much? ___

If Known, Family history of:

Depression: yes ___ no ___ which relative/s? _____
Anxiety: yes ___ no ___ which relative/s? _____

Other mental health issues in family:

Describe: _____ which relative/s? _____
Describe: _____ which relative/s? _____
Substance abuse: yes ___ no ___ which relative/s? _____

Date of last physician visit/physical: _____

Have there been any recent **changes** in your physical condition? No ___ Yes ___

If yes, please specify _____

What are your greatest **strengths**? (Personal Qualities or things you do well?) _____

Who are your Supports? _____

Main reason/s for gaining counseling at this time/biggest challenges/what do you wish to accomplish in counseling? _____

