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Children and Adolescents Self Report Form (18 and under only)

Client's name: _____ Age _____ Date _____

Name of person completing this form and relationship to client:

1. Briefly describe the problem that brought you here today:

Please check behaviors and symptoms that occur to you more often than you would like them to take place: List the onset and frequency of each checked behavior/symptom (i.e., 2 months ago, 3-4x wk)

- | | | |
|---|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gambling | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Generous | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Shares |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Irritable | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Lazy | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Loner | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Messy | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moody | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Obedient | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Often sick | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Drugs dependence | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Over active | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Overweight | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Phobias | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Psychiatric problems | _____ |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Quarrels | _____ |

Psychiatric Treatment

2. Is client currently under the care of a therapist and/or psychiatrist for current or another problem? YES NO

Provider's name(s): _____

3. Has Client ever been treated in the past for psychiatric, substance abuse, emotional, or behavioral problems? YES NO

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

Inpatient _____ Outpatient _____

Did you find past treatment helpful? YES NO

4. Please list psychiatric medications and dosages given in past and results:

5. Please list any current psychiatric medications and dosages prescribed to the client.

6. Has clients' family members currently or in the past been under the care of a therapist and/or psychiatrist? YES NO

MEDICAL PROBLEMS

7. Does the client have any current medical problems? YES NO

If yes, please list: _____

8. When was the last time the client was seen by a doctor? _____

9. Are immunizations up to date? YES NO

10. Is client currently taking medication for medical problems? YES NO

If yes please list medication, dosage, and purpose: _____

11. Are there any allergies and/or medication allergies? YES NO

If yes, please list: _____

12. Is there any history of head injury, seizures, loss of consciousness, or extended high fevers? YES NO

13. Would you like information from today's visit communicated to your

primary care provider or any other medical doctor? YES NO

If yes, list doctor's name, phone number, address:

Developmental Factors

14. Were there problems with pregnancy or delivery? YES NO If yes, please describe:

15. Was there any exposure to alcohol, tobacco, or other drugs during pregnancy? YES NO If yes, describe:

16. Were there any developmental problems (e.g. did patient walk/talk at appropriate ages)? YES NO If no, describe:

SUBSTANCE ABUSE

17. Does the client have/had problems with or treatment for drugs, alcohol, or other addictions? YES NO

18. Does the client currently attend support groups? YES NO

19. Please circle any of the following that the client have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, methamphetamines/speed, methadone, LSD, PCP, Ecstasy, inhalants.

If you circled any of the above substances, list the last time each substance was used & the average amount and frequency of use:

20. Does anyone in client's extended family have/had problems with drugs, alcohol, or other addictions? YES NO If so, relationships?

21. Have there been any problems/trouble related to substance abuse? YES NO

For ages 12 and up only – Please have adolescent complete the following:

1. Have you ever ridden in a car driven by you or someone else who was using alcohol/drugs? YES NO

2. Do you ever use alcohol or drugs to relax, feel better or fit in? YES NO

3. Do you ever use alcohol or drugs while you are alone? YES NO

4. Do you ever forget things you did while using drugs or alcohol? YES NO

5. Do your family or friends ever advise you to cut down on your drinking or drug use? YES NO

6. Have you gotten into trouble while you were using alcohol or drugs? YES NO

LEGAL ISSUES

22. Does client have/had problems with school or legal systems? YES NO

If yes, describe: _____

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23. Is client currently on probation/parole? YES NO

24. Is a DFACS worker involved? YES NO

Educational/Work Concerns

25. Are grades.. ___average ___above average ___below average? Has there been a significant drop in grades recently? YES NO

26. Check any that apply: ___learning disabilities ___developmental disabilities ___special education ___alternative school ___home school

27. List grade and name of school: _____

28. Is client experiencing difficulties in school? YES NO. If yes, please explain:

29. Are there any problems related to language/speech/hearing/vision? YES NO

30. Does the client have an IEP in effect? YES NO

FAMILY/RELATIONSHIPS

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

Relationship	Name	Age
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

32. List other extended family involved with client (include name, relationship and age):

33. Are both biological Mother/Father in the home? YES NO

If no, please explain: ___ Divorced ___ Separated ___ Single Parent Family ___ Step Family ___ Other

34. Do client have contact with non custodial parent? YES NO

35. Does anyone in the family have psychiatric, emotional, substance abuse, or behavioral problems? YES NO

If so, please describe: _____

36. Is there any history of sexual and/or physical abuse? YES NO

37. Was client exposed to any domestic violence events? YES NO

38. Who is in client's support network (i.e. friends, family, religious organizations)?

39. List any spiritual/cultural/ethnic considerations that could impact therapy:

40. List client's strengths/resource and hobbies/interests:

41. Are there difficulties or concerns about how the client gets along with other people? YES NO

42. Does the client have any sexual orientation/gender issues or concerns? YES NO

43. Are there any other stressors or any additional information that would assist in understanding the current concern?

44. Do you believe the client is suicidal at this time? YES NO

44. What are your goals for therapy? What would you like to see changed specifically?

Signature of client or person completing this form: _____

Date: _____

Signature of therapist: _____

Date: _____