



Dependent Child/Adolescent Self Report

Name _____

Date _____

Residential Parent(s)/Guardian(s) _____

Non-Custodial or Non-residential parent (if applicable) _____

Address _____

Phone number _____

Why are you coming in for counseling?

Symptoms:

None = this symptom not present at this time

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and /or day-to-day functioning

Severe = Profound impact on quality of life

	None	Mild	Mod	Sev		None	Mild	Mod	Sev		None	Mild	Mod	Sev
depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	related medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been hospitalized for mental health treatment? ____ yes ____ no

Describe _____

Have you ever had prior mental health counseling or treatment? ____ Yes ____ no

Describe _____

Have you ever participated in any form of self harm before? ____ yes ____ no what _____

Do you have any suicidal thoughts at this time? ____ Yes ____ no

Have you ever tried to commit suicide? ____ Yes ____ no How _____



Do you experiment with alcohol? ____ Yes ____ no

Do you experiment with drugs? ____ Yes ____ no what _____

Unconscious Life

Nightmares and/or recurring dreams? _____

Unconscious habits? _____

Fears with unknown origins? _____

Obsessive/Compulsive acts or thoughts? (Behaviors you repeat over again and again or keep thinking about the same thing all the time) _____

School Life

Your School _____

Grade level _____

Three things you enjoy about school

- 1. _____ 2. _____ 3. _____

Three things that irritate you about school

- 1. _____ 2. _____ 3. _____

Do you have a job? Where? _____

What do you hope to be or do after you are finished with school? _____

Social Life

Who would you consider to be your best friend and why? _____

What type of people are you comfortable with (quiet, loud/talkative, leaders, etc) _____

Would you consider yourself more of a leader or a follower? _____

What is your attitude toward social functions? _____

List the things you most enjoy doing with your free time _____

Relationships (How is your relationship...)

Between you and your mom? _____

Between you and your dad? _____

Between you and your step- mom? _____

Between you and your step- dad? _____

Your most important relationship is you and _____

What make it so important? _____



The best thing that ever happened in your life? _____

The worst thing that ever happened in your life? _____

Sexual Life (if older than age 11)

When and by whom did you learn about sex _____?

How do you feel about sex? _____

Are you currently sexually active? _____

Spiritual Life

What place does religion apply in your home today? _____

What are your beliefs about God? _____

Are you a practicing Christian? _____ if no, please disregard the next section

Christian Belief System

When and how did your Christian life begin? _____

Do you pray regularly? _____

Do you read the Bible? _____

Are you fearful of going to hell? _____

Are you fearful of not being forgiven? _____

If you could ask God for 3 things, what would they be? _____

What would you consider the worst sin a person could commit, and why? _____
