Name:_____ Age_____Date:_____

SELF-REPORT FORM Age 11-17

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

	Extremely				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: For how many ___yrs ___months ___weeks ___days?	4	3	2	1	0
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

	Extremely				Not at all
Lack of assertiveness/being taken advantage of:	4	3	2	1	0
Aggressive/violent behavior toward others:	4	3	2	1	0
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

	Extremely				Not at all
Issues with food/eating: __Bingeing, __Purging, __restricting food intake	4	3	2	1	0
Unwanted/Intrusive/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?**_____
_____
Supports?_____
What areas do you feel most **challenged** in?_____
_____

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