Client Self-Report Questionnaire

Instructions:
Please read each statement carefully. Circle the number that best describes how true the statement has been within the past 7 days. Check only one answer for each statement.

Instructions for Parents/Guardians:
If your child is under 12, the parent or guardian is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child..." or "My child's..." rather than "My..." or "I..." It is important that you answer as accurately as possible, based on your own observation and knowledge.

Client Name: ________________________________ **Today's Date: ___________________**

Date of Birth: ________________________________ **Grade/Age: ____________________**

1. I have headaches or feel dizzy 0 1 2 3 4
2. I don't participate in activities that used to be fun 0 1 2 3 4
3. I argue or speak rudely to others 0 1 2 3 4
4. I have a hard time finishing my assignments or do them carelessly...............................0 1 2 3 4
5. My emotions are strong and change quickly...0 1 2 3 4
6. I have physical fights (hitting, biting, or scratching) with family or peers 0 1 2 3 4
7. I worry and can't get thoughts out of my mind 0 1 2 3 4
8. I steal or lie..0 1 2 3 4
9. I have a hard time sitting still (or I have too much energy) 0 1 2 3 4
10. I use alcohol or drugs...0 1 2 3 4
11. I am tense and easily startled (jumpy)...0 1 2 3 4
12. I am sad or unhappy...0 1 2 3 4
13. I have a hard time trusting family members or other adults.......................................0 1 2 3 4
14. I think that others are trying to hurt me even though they are not...........................0 1 2 3 4
15. I have threatened to, or have run away from home...0 1 2 3 4
16. I physically fight with adults..0 1 2 3 4
17. My stomach hurts or I feel sick more than others my age...0 1 2 3 4

18. I don't have friends or I don't keep friends very long..0 1 2 3 4
19. I think about suicide or feel I would be better off dead..0 1 2 3 4
20. I have nightmares, trouble getting to sleep, oversleeping, or waking too early..........0 1 2 3 4
21. I complain about or question rules, expectations, or responsibilities........................ 0 1 2 3 4
22. I break rules, laws, or don't meet expectations on purpose.......................................0 1 2 3 4
23. I feel irritated..0 1 2 3 4
24. I get angry enough to threaten others...0 1 2 3 4
25. I get in trouble when I am bored..0 1 2 3 4
26. I destroy property on purpose.. 0 1 2 3 4
27. I have a hard time concentrating, thinking clearly, or staying on task........................0 1 2 3 4
28. I withdraw from my family and friends...0 1 2 3 4
29. I act without thinking and don't worry about what will happen............................... 0 1 2 3 4
30. I feel that I don't have any friends or that no one likes me.. 0 1 2 3 4

Insurance:

Name of Insurance: ______________________________ Member ID: __________________________

Subscriber's Name: ____

Subscriber's Address: ____

Health:

Please list any medications you are currently taking: ____

____

Please list any Inpatient Treatment, Partial Hospitalization, or Intensive Outpatient services you have had:____

____

Please list any prior counseling services you have had:_______________________________________

____

What went well? ____

Did anything not go well? Please explain: ____

____

Please list any medical issues: ____

Family:

Who lives in your home? ____

Please list any family members who do not live in your home? __________________________________

____

Are there any family issues that you would like to mention?_____________________________________

____

____

School:

What school do you attend? ____

Do you like school? Yes/Neutral/No What is your favorite class? _____________________________

Do you have friends at school? _________________ Outside of school? _______________________

Do you have an IEP? Yes/No List any classes you are struggling in: ______________________________

Contact:

Please provide your phone number: _____________________E-mail: _____________________________

Emergency contact: ____

Please describe the problem or concern that brings you here:

____

____

____

____

____

When did the problem or concern begin?_______________________________________

____

____

____

Please rate the severity of your concern on the scale below:

Low 0 1 2 3 4 5 6 7 8 9 10 High

What are your interests and strengths?

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____

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____

What is your desired outcome for therapy?

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Thank you for completing the Questionnaire!