



Client Number \_\_\_\_\_

**Office use only:**  
DSM-IV Code \_\_\_\_\_  
Session Fee \$ \_\_\_\_\_

### Dependent Child/Adolescent Self Report

Last updated 06/05/01

The following questions are intended to gather information about your health. This information is voluntary, and may aid in the identification of physical disorders or conditions that may be relevant to the mental health services provided to you at WellSpring.

Counselor \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State/Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_

Residential Parent(s)/Guardian(s) \_\_\_\_\_ / \_\_\_\_\_

Employer(s) and Phone #(s) \_\_\_\_\_ / \_\_\_\_\_

May we contact you at work? \_\_\_\_\_yes \_\_\_\_\_no

Non-Custodial or non-residential parent (if applicable) \_\_\_\_\_

Address/Phone # \_\_\_\_\_

Employer(s) and Phone #'s \_\_\_\_\_

May we contact them at work? \_\_\_\_\_yes \_\_\_\_\_no

Please list all persons currently living in the client's household excluding client and residential parent(s) listed above.

| Last name | First Name | Relationship w/Client | Sex | Birth Date | Health |
|-----------|------------|-----------------------|-----|------------|--------|
|           |            |                       |     |            |        |
|           |            |                       |     |            |        |
|           |            |                       |     |            |        |
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|           |            |                       |     |            |        |
|           |            |                       |     |            |        |

**Presenting Concern(s)** What issue(s) bring you in for counseling?



**Client's Present Physical Condition**

Height\_\_\_\_\_ Weight\_\_\_\_\_ Appetite\_\_\_\_\_

|                       |             |             |             |
|-----------------------|-------------|-------------|-------------|
| <i>(Please Check)</i> | <u>Good</u> | <u>Fair</u> | <u>Poor</u> |
| General Health:       |             |             |             |
| Vision:               |             |             |             |
| Hearing:              |             |             |             |

Effects of earlier operations or hospital stays\_\_\_\_\_

Any bowel or urinary malfunctions\_\_\_\_\_

Any use of: \_\_\_\_\_Alcohol \_\_\_\_\_Drugs \_\_\_\_\_Tobacco \_\_\_\_\_Caffeine

Allergies:\_\_\_\_\_

Do you have any significant physical problems\_\_\_\_\_ Please explain\_\_\_\_\_

Approximately how long ago were you examined by your personal physician?  
\_\_\_\_\_

List any personal physicians you have\_\_\_\_\_

**Client's Mental Health**

Have you had any prior mental health counseling, evaluation, or treatment? \_\_\_yes\_\_\_no  
List and describe:

| <u>Agency Name</u> | <u>Address</u> | <u>Phone</u> | <u>Therapist</u> | <u>Dates</u> |
|--------------------|----------------|--------------|------------------|--------------|
|                    |                |              |                  |              |
|                    |                |              |                  |              |
|                    |                |              |                  |              |

Have you ever been hospitalized for mental health treatment? \_\_\_yes\_\_\_no  
Describe:\_\_\_\_\_

Have you ever tried to commit suicide? \_\_\_yes\_\_\_no When?\_\_\_\_\_

Do you have any suicidal thoughts at this time? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list any medications you are currently taking:

| <u>Medication</u> | <u>Dosage/Frequency</u> | <u>Prescribing Doctor</u> |
|-------------------|-------------------------|---------------------------|
|                   |                         |                           |
|                   |                         |                           |
|                   |                         |                           |



**School Life**

Client's School \_\_\_\_\_ Phone # \_\_\_\_\_  
Grade level \_\_\_ Counselor \_\_\_\_\_ Teacher \_\_\_\_\_  
Recent Evaluative Testing Completed \_\_\_\_\_

Three things you enjoy about school  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Three things that irritate you about school  
1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Do you have a job? With whom? \_\_\_\_\_

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 types of people are you comfortable with?

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

What is your attitude toward social functions?

Girlfriend/Boyfriend? (if applicable) Name \_\_\_\_\_ Age \_\_\_\_\_

**Enjoyment / Recreation / Relaxation**

WHAT'S FUN?!! List the things you most enjoy doing with your leisure time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Unconscious Life**

Sleep Well? \_\_\_\_\_ How Long? \_\_\_\_\_ Aided by drugs? \_\_\_\_\_

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?) \_\_\_\_\_  
\_\_\_\_\_

**Emotional 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? \_\_\_\_\_



Between you and your brothers/sisters? \_\_\_\_\_  
 Between you and another important person to you? \_\_\_\_\_  
 Your most important relationship is you and \_\_\_\_\_  
 What makes it so important? \_\_\_\_\_

The best thing that ever happened in your life? \_\_\_\_\_

The worst thing? \_\_\_\_\_  
 If you could change anything about your life, what would it be? \_\_\_\_\_

**Optional Section**

*Please fill out the information below only if it is age appropriate and/or applicable for you or your child.*

**Sexual Life (If older than age 11)**

When was the client initially informed about sex? \_\_\_\_\_ By whom? \_\_\_\_\_  
 How? \_\_\_\_\_

How does the client feel about sex? \_\_\_\_\_

Is the client 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? \_\_\_\_\_

Read the Bible regularly? \_\_\_\_\_

Are you fearful of going to hell? \_\_\_\_\_

Of not being forgiven? \_\_\_\_\_

Do you have favorite Bible verses? Which and Why? \_\_\_\_\_

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? \_\_\_\_\_



What would you consider the most Christian deed a person could perform, and why? \_\_\_\_\_

Who is the most influential Christian in your life today and why? \_\_\_\_\_

What would you consider to be the best things about being a Christian? \_\_\_\_\_

The worst things? \_\_\_\_\_

How do you feel about your church experience? \_\_\_\_\_