Blue Ridge Counseling

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YOUTH SELF-REPORT

NAME: _____ DATE: _____

DATE OF BIRTH: _____ PHONE: _____ CELL (if applicable): _____

PARENT/GUARDIAN NAME(S): _____

PERSONAL/FAMILY PHYSICIAN: _____

WHY ARE YOU SEEKING COUNSELING OR TREATMENT SERVICES AT THIS TIME?

_____

_____

Are you experiencing a great deal of emotional stress or problems in your life? Please check one:

☐ Yes, a lot ☐ More than usual ☐ Occasionally ☐ Rarely

Are you having relationship problems with (please check all that apply)?

☐ Family members ☐ Spouse/significant other ☐ Remarried family issues ☐ People at Work

☐ People at school ☐ Specific friend ☐Supervisor ☐ Teacher

☐ Other (please explain) _____

CHECK ALL ITEMS BELOW THAT APPLY TO YOUR CURRENT SITUATION:

☐ Headaches	☐ Sexual problems	☐ Drinking problems	☐ Dizziness
☐ Financial problems	☐ Drug problems	☐ Stomach trouble	☐ Feel like crying
☐ Unable to have a good time	☐ Bowel trouble	☐Panicky feelings	☐ Changes in appetite
☐ Trouble Concentrating	☐ Hard time with friendships	☐ Tremors or tics	☐ Feel tense, uptight
☐ Always worried	☐ Feel apart from people	☐ Irritable	☐ Unable to relax
☐ Frightened, feel scared	☐ Unusual thoughts	☐ Feel worthless	☐ Family conflict
☐ Eating problems	☐ Can't make decisions	☐ Feel I will lose control	☐ Weight change
☐ Suicidal thoughts	☐ Angry a lot	☐ Feel tired a lot	☐ Ready to explode
☐ Put up a good front	☐ Sleep problems	☐ Too much energy	☐ Lonely
☐ Nightmares	☐ People are out to get me	☐ Low self-esteem	☐ Depressed, down
☐ Temper problems	☐ Legal problems	☐ Anxious, worry a lot	☐ Misunderstood
☐ Racing thoughts	☐ Thoughts of death or dying	☐ Loss of interest in things	☐ Hearing voices

Please continue on page 2.

□ Seeing things others don't □ Unemployment □ Job problems □ School problems

If you are currently employed, how satisfied are you with your job? Please check one:

□Very satisfied □ Moderately satisfied □ Satisfied □ Moderately dissatisfied □ Very dissatisfied

Please check any that apply:

□ Vision Impairment □ Hearing Impairment □ SSI/Disabled □ Pregnant

□IV Drug User □ HIV+

PLEASE CONTINUE ON PAGE 2.

How is your spiritual life right now? Please check one:

□ In good shape □ Developing □ Very poor □ None

How many changes would to like to make in yourself? (please check one)

□ Many □ Several □ A Few □ None

Have you experienced a traumatic event in past? Please check all that apply:

□ Domestic Violence □ Abuse □ Serious Accident □ Natural Disaster

□ Other (please explain): _____

Have you ever talked to anyone (psychologist, psychiatrist, counselor, minister/priest, etc.) about your personal problems? □ Yes □ No

If yes, who? _____ Last contact date: _____/_____/_____
Month/ Day / Year

Please indicate any past hospitalizations in a mental health facility, if any.

Facility Name	**Date(s)**	**Reason**
_____	_____	_____
_____	_____	_____

Are you currently taking any Psychiatric Medications? Please check: □ Yes □ No

If yes, please list current Psychiatric Medications:

1. _____ 2. _____

3. _____ 4. _____

Are these medications helpful? Please check: □ Yes □ No

Have you taken any Psychiatric Medications in the past? Please check: □ Yes □ No

If yes, please describe _____

Were they helpful? Please check: □ Somewhat □ Yes □ No

Do you have a physical health condition or serious illness? □ Yes □ No

If yes, please describe: _____

Are you taking any medication for a physical health condition or serious illness? □ Yes □ No

If yes, please list/explain: _____

Do you have any allergies or drug sensitivities? Please check: □ Yes □ No

If yes, which ones? _____

Please list the problems, events, significant losses, or changes that create the most stress at the present time.

1. _____

2. _____

3. _____

What do you hope to gain from our services?

_____

_____

How strongly would you like to talk with a counselor about your concerns? Please check one:

□ A lot □ Much □ A little □ Not really

Thank you for providing this information.