Adolescent Self-Report Form

Instructions: In order for your therapist to better understand your situation, please fill out this form as clearly as you can. PLEASE PRINT YOUR ANSWERS.

These questions give general information about you. Name: Today's Date:	Identifying Informati					
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13. Describe any problems or difficulties with family members:					
School These questions provide information about how things are going in school.					
14. How many schools have you attended?					
15. What subjects do you like the best?					
16. List subjects that you do <u>not</u> do well in?					
17. What kind of grades do you usually get?					
18. What gets you in trouble at school?					
19. Have you ever repeated a year/grade? YesNo					
20. Have you ever been in a special class of any kind?YesNo					
21. List any school activities that you are involved in (sports teams, clubs, music, etc.):					
22. Describe any problems or difficulties related to school:					
Outside of School These questions are about your life outside of school. 23. List the types of things you do after school:					
24. What types of things do you do in the evenings?					
25. What time do you usually go to bed on weeknights? 26. On weekends?					
27. On a typical day, how many hours do you spend on each activity? Watching TV: Working on the computer: Playing video games: Listening to music:					
28. Do you currently work? Yes No If yes, describe your present job:					

29. What gets you in trouble outside of school?	
30. Briefly describe any special hobbies or interests:	
Friends These questions are about your social connections.	
31. Do you have close friends? Yes No	32. If yes, how many?
33. Do you spend time with friends outside of school? Yes	No
34. Do you have difficulty making friends? Yes No 3	5. Difficulty keeping friends? Yes No
36. Are you a shy person? Yes No 37. Do you get ner	vous around other kids your age: Yes No
38. Do you have a boyfriend or girlfriend? Yes No	
39. List all your dating relationships and how long they have la	ested:
Name: Length of Dating Rela	itionship:itionship:itionship:itionship:itionship:itionship:itionship:
	tionship:
Areas of Concern At times everybody experiences problems. These next question about.	
41. Please check off all areas of concern: Sadness Nervousness and Worry Tired all the time Difficulties with attention and staying focused Shyness Not fitting in with other kids Loneliness Conflict with parents Conflict with brothers or sisters Other (Please describe symptoms): Unsure (Please describe symptoms):	
42. Describe in your own words any problems or difficulties you	
43. Under what conditions are your problems worse?	

44. Under what conditions are they better?	
45. What types of things would have to change to make your life better?	
46. Additional information that you think might be helpful:	