CORNERSTONE
FAMILY SERVICES

Dependent Adolescent/Child Self-Report

The following questions are designed to gather information about you and your health, and your relationships. This information is voluntary and may aid in the identification of conditions that are relevant to services provided to you.

Client Name: _____ Client Birth Date: _____

Client Address_____ City:_____

State: _____ Zip Code: _____ Phone:_____ Gender: ___M ____F

Please list all persons living in client's current household (exclude self):

First name	Last name	Relationship to Client	Sex	Birth Date	Health Status

Presenting Concern (What brings you in for counseling?)**:** use back of last page if necessary

What symptoms do you experience as a result of this concern? (physical and/or emotional)

What will be different if counseling is successful?

Client's Mental Health

Have you had any prior mental health counseling, evaluation, or treatment? ____yes ____no
If yes:

Name	Phone	Fax	Dates Seen

Have you ever been hospitalized for mental health treatment? ___yes ___no
If yes, please describe:

Have you ever tried to commit suicide? ___yes ____no
If yes, when?

Do you have any suicidal thoughts at this time? ___Yes ___No

Please list any medications you are currently taking:

Medication	Dosage	Prescribing Doctor

Unconscious Life

Sleep Well? ___yes ___no How Long? Aided by drugs? ____yes ____no

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?)

School Life

Client's School Phone #

Grade level _____ School Counselor _____ Homeroom Teacher _____

Three things you enjoy about school
1.

2.

3.

Three things that irritate you about school
1.

2.

3.

Do you have a job? ___yes ___no If yes, 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) If yes, name & age?

Enjoyment / Recreation / Relaxation

WHAT'S FUN?!! List the things you most enjoy doing with your leisure 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 between you and:
What makes it so important?

The best thing that has ever happened in your life?

The worst thing that has ever happened in your life?

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 and 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

How did you become a Christian? When?

Do you pray regularly? ____ Yes ____ No

Do you read the Bible regularly? ____ Yes ____ No

Do you suffer feelings of guilt? ____ Yes ____ No

Are you fearful of hell? ____ Yes ____ No

Are you fearful of not being forgiven? ____ Yes ____ No

Who is your favorite Bible character? Why?

What is your favorite Bible passage? Why?

What would you consider to be the worst sin a person could commit and why?

Briefly describe your view of a Biblical marriage:

Any other relevant information regarding your Christian experience?