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Client Self-Report Form

Name: ______________________________ **Date:** __________________

Please check items that you consider problematic:

☐	Sadness/depression	☐	Panic attacks	☐	Impulsive behavior	☐	Reoccurring nightmares
☐	Hopeless/helpless thinking	☐	Risk aversion: Avoiding unfamiliar people, places or activities	☐	Obsessive/ compulsive behavior	☐	Chronic, free floating feeling of tension/stress
☐	Changes in appetite	☐	Anxiety/fear	☐	Computer addiction	☐	Intrusive thoughts/images
☐	Sleep problems	☐	Excessive worry	☐	Alcohol/drug abuse or dependence	☐	Hypervigilance
☐	Loss of pleasure/boredom	☐	Social discomfort/self-consciousness	☐	Gambling problems	☐	Flashbacks
☐	Low self-worth/esteem	☐	Lack of social connection/loneliness	☐	Excessive spending problems	☐	Avoidance of certain people, places, situations
☐	Crying spells	☐	Memory problems for past or recent events	☐	Sex addiction/ problems with pornography	☐	Increased startle response
☐	Seasonal mood changes	☐	Easily distracted/ problems concentrating or sustaining focus	☐	Eating/body image problems	☐	Feeling detached, unreal or numb
☐	Suicidal thoughts/ morbid preoccupation	☐	Problems with procrastination	☐	Anger management problems	☐	Losing time/dissociation
☐	Heightened sensitivity/irritability	☐	Suspiciousness/paranoia	☐	Passive behavior/ low assertiveness	☐	Wide mood swings
☐	Fatigue	☐	Visual/auditory hallucinations	☐	Family/parenting problems	☐	Excessive energy/ hyperactive or manic behavior
☐	Withdrawal from people	☐	Physically aggressive behavior	☐	Work/school problems	☐	Racing thoughts/ disorganized thinking
☐	Guilt/shame	☐	Thoughts of harming/ retaliating against others	☐	Relationship/marital problems	☐	Other:
☐	Lack of motivation/ low self-initiative	☐	Self-harm/injurious behavior	☐	Problems related to a life transition		

Please check areas that are affected by the above items:

☐ Primary/marital relationship	☐ Parenting/family life	☐ Work/school	☐ Money/finances
☐ Physical/sexual health	☐ Social/recreational activity	☐ Handling daily tasks	☐ Housing/transportation

History of problem:

Time period	**Details of problem**
Childhood	
Adolescence	
Adulthood	

Current treatment: ☐ **No current treatment**

Provider/program	Contact information	Summary of treatment (e.g. diagnosis, duration, schedule, progress)

Previous treatment: ☐ **No previous treatment**

Provider/program	Contact information	Summary of treatment (e.g. diagnosis, duration, outcome)

Psychiatric hospitalizations: ☐ **No psychiatric hospitalizations**

Hospital	Dates	Reason

High risk behavior:

Suicidal behavior: ☐ **No suicidal behavior**

☐	Frequent and severe
☐	Mild/moderate and occasional
☐	Frequent morbid, but not suicidal thoughts/images
☐	Current plan for suicide including timeline. Details:
☐	Past suicide attempt/s including timeline. Details:

Aggressive behavior: ☐ **No aggressive behavior**

Type of aggressive behavior	☐ Physical aggression toward others ☐ Verbal aggression toward others ☐ Destruction of property ☐ Cruelty toward animals ☐ Other:
Circumstances?	

Trauma: ☐ **No trauma**

Type of trauma	☐ Sexual abuse ☐ Physical abuse ☐ Verbal Abuse ☐ Physical Neglect ☐ Emotional Neglect ☐ Other:
Circumstances?	

Legal history: ☐ **No legal history**

☐ On probation	☐ Convicted of felony	☐ Involved in custody case	☐ Legal charges
☐ Convicted of misdemeanor	☐ Involved in divorce	☐ DUII	☐ Other:
Circumstances?			

Substance use/abuse: ☐ **No substance use/abuse**

Current substance use/abuse	☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Methamphetamines ☐ Ecstasy ☐ Heroin ☐ Inhalants ☐ LSD ☐ Steroids ☐ Cigarettes ☐ Prescription medications, Type:
Quantity of substance use/abuse	Amount and frequency:
History of substance use/abuse	When started and how long:
Previous treatment	☐ Outpatient ☐ Residential ☐ Day Treatment ☐ Other:
Family history	☐ Father ☐ Mother ☐ Siblings ☐ Grandparents ☐ Aunts/Uncles ☐ Other:

Do you have withdrawal symptoms when not using substance (e.g. physical cravings, illness, anxiety)?
☐ No ☐ Yes, details:

Have you built tolerance for the substance (i.e. do you need to use more to get the same effect)?
☐ No ☐ Yes, details:

Do you have problems due to substance use (e.g. work, relationships, health, legal)?
☐ No ☐ Yes, details:

Medical/developmental status:

Height:	Weight:
General medical concerns (e.g. cancer, arthritis, heart, thyroid, neurological disease)	☐ No ☐ Yes, details:
History of head trauma	☐ No ☐ Yes, details:
History of major accidents/illnesses	☐ No ☐ Yes, details:
Allergies (e.g.to food, medications, etc.)	☐ No ☐ Yes, details:
Medical problems that run in your family	☐ No ☐ Yes, details:
Other notes about your health	
Primary care provider	Name: Last visit:

Prescription medications ☐**No prescription medications**

Medication	Dosage	Start Date	End Date	Prescribed by

Family-of-origin information:

Parents	Age(s):
Siblings	Gender(s): Age(s):
Parents/siblings still alive	☐No ☐Yes, if no, when deceased:
Parents still married	☐No ☐Yes, if yes, duration:
Parents divorced	☐No ☐Yes, if yes, date of divorce:
Parents remarried	☐No ☐Yes, if yes, how many times and duration:
Half or step-siblings	Gender(s): Age(s):

Immediate family information:

Married or partnered	☐No ☐Yes, if yes, duration:
Children	Gender(s): Age(s):
Divorced	☐No ☐Yes, if yes, date of divorce:
Remarried	☐No ☐Yes, if yes, how many times and duration:
Step children	Gender(s): Age(s):

Education/military history:

Highest level of education	
GPA at graduation or college major	
Military type/status (past and current)	

Is there anything else you want Dr. Kim to know about you?