

**TATIANA MATTHEWS**

**PATIENT SELF-REPORT: CHILD/ADOLESCENT  
(18 AND UNDER ONLY)**

Patient Name: \_\_\_\_\_ Age: \_\_\_ Date: \_\_\_\_\_

Name of person completing this form (if not patient) \_\_\_\_\_

1. Briefly describe the problem which brought you here today: \_\_\_\_\_

\_\_\_\_\_

2. Is the patient having thoughts of hurting themselves or someone else?  
YES NO If yes, please explain: \_\_\_\_\_

Has the patient ever had thoughts of hurting themselves or someone else?  
YES NO

**THERAPIST  
COMMENTS**

**PAST AND CURRENT TREATMENT**

3. Has the patient ever been treated for psychiatric, substance abuse, emotional,  
or behavioral problems in the past? YES NO If yes, when, where, and  
with whom? \_\_\_\_\_

Did you find past treatment helpful? YES NO

4. Is the patient currently under the care of a psychiatrist, therapist, school  
counselor, or pediatrician for a psychiatric problem? YES NO

5. Has the patient ever taken psychiatric medications in the past? YES  
NO If yes, please list name(s) and dosage(s): \_\_\_\_\_

\_\_\_\_\_

6. Is the patient currently taking any psychiatric medications? YES NO  
If yes, please list name(s) and dosage(s): \_\_\_\_\_

\_\_\_\_\_

**FAMILY'S TREATMENT**

**Page 1**

7. Have any of the patient's family members currently or in the past been under the  
care of a psychiatrist or therapist? YES NO If yes, which family member  
and for what reason? \_\_\_\_\_

\_\_\_\_\_

**MEDICAL PROBLEMS**

8. Does the patient have any current medical problems? YES NO If yes, please explain:\_\_\_\_\_

9. Has the patient ever had any significant medical problems in the past? YES NO If yes, please explain:\_\_\_\_\_ **THERAPIST COMMENTS**

10. Are immunizations up to date? YES NO

11. Are there any allergies or medication allergies? YES NO If yes, please list:\_\_\_\_\_

12. Is the patient currently taking medication for medical problems? YES NO If yes, please list medication, dosage, and purpose:\_\_\_\_\_

13. Does the patient have a history of head injury, seizures, loss of consciousness, or extended high fevers? YES NO If yes, please list:\_\_\_\_\_

14. Would you like information from today's visit communicated with your pediatrician or any other medical doctor? YES NO

**DEVELOPMENTAL FACTORS**

15. Were there problems with pregnancy or delivery? YES NO If yes, please describe:\_\_\_\_\_

16. Was there any exposure to alcohol, tobacco, or other drugs during pregnancy? YES NO If yes, please describe:\_\_\_\_\_

17. Did the patient have any problems with walking, talking, toilet-training, or other developmental milestones? YES NO If yes, please explain:\_\_\_\_\_

### **SUBSTANCE ABUSE**

18. Does the patient use (or do you suspect that the patient uses) any alcohol or drugs? YES NO

19. Does the patient currently attend support groups? YES NO

20. Does anyone in the patient's household have any substance abuse problems? YES NO

21. Circle any of the following that the patient has used in the past 30 days: alcohol, tobacco, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, methamphetamines/speed, LSD, PCP, Ecstasy, inhalants.

22. Have there been any problems related to substance abuse (school/legal/DUI)? YES NO

**THERAPIST  
COMMENTS**

### **LEGAL ISSUES**

23. Does the patient have/had problems with school or the juvenile justice system? YES NO

24. Is the patient currently on probation or parole? YES NO

25. Are there any legal issues such as: (Please check)  
\_\_Divorce in process \_\_Possible custody battle  
\_\_Going to court

26. Is a DFACS worker involved? YES NO

### **EDUCATIONAL/WORK CONCERNS**

27. Are grades...\_\_average, \_\_above average, or \_\_below average?

28. Has there been a significant drop in grades recently? YES NO

29. Check all that apply: \_\_learning disabilities, \_\_developmental disabilities, \_\_special education, \_\_alternative school, \_\_home school.

30. List grade and name of school: \_\_\_\_\_

31. Please circle current educational/job status: current student, GED, part-time job, full-time job.

32. List any problems related to hearing/speech/vision: \_\_\_\_\_  
\_\_\_\_\_

33. Has the patient had a psychological evaluation/testing done in school?  
YES NO

34. Does the patient have an IEP in effect? YES NO

### FAMILY/RELATIONSHIPS

35. Please list anyone who lives in the home, his/her age, and relationship:  
\_\_\_\_\_

36. List other extended family involved with the patient: \_\_\_\_\_  
\_\_\_\_\_

**THERAPIST  
COMMENTS**

37. Are both biological mother/father in the home? YES NO  
If no: \_\_divorced \_\_separated \_\_single parent family  
\_\_stepfamily \_\_other

38. If divorced, what are the custody arrangements? \_\_\_\_\_  
\_\_\_\_\_

Does the patient have contact with the parent they do not live with?

YES NO If yes, please describe how often \_\_\_\_\_  
\_\_\_\_\_

39. Does anyone in the patient's immediate or extended family have psychiatric, emotional, substance abuse, or behavioral problems? YES NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

40. Has the patient survived any sexual or physical abuse? YES NO

41. Has the patient witnessed any domestic violence? YES NO

42. Is the patient's support network: Good Moderate Poor

43. What are the patient's hobbies/interests? \_\_\_\_\_  
\_\_\_\_\_

44. Are there difficulties or concerns about how the patient gets along with other people?    YES    NO

45. Does the patient have any sexual orientation/gender issues or concerns?    YES    NO

46. Are there any transportation or financial concerns that would impact treatment?    YES    NO

---

Patient (or person completing this form) signature

Date

I have reviewed and discussed this information with the patient.

---

Therapist Signature/Credentials

Date