Dr Marti Fausold-Mowers
ADOLESCENT / YOUNG ADULT SELF REPORT FORM
To be filled out by Patient

NAME Enter Patient's Name

DATE of BIRTH

Address Enter Street City, State, Zip

To Day's DATE

Cell Phone

Do I have your permission to leave VM/Texts at the number indicated? ☐

Email Address

Do I have your permission to email this address if I need to reach you? ☐

Parents Names	Parents Address

Please describe any difficulties you are experiencing with the following people:

Parents / Step Parents / Guardians

Siblings / Step Siblings

Friends

School Name Grade

How are your grades?

Any problems in School?

Do you work? If so, where?

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Please describe the reasons you are attending therapy?

If you have received therapy in the past, describe what it was for and what your experience was like?

Who are your close friends? What are they like?

Are you in a romantic relationship? If so, do you have any concerns with it?

Do you drink alcohol/use recreational drugs? If so, please describe what and how often

What worries you?

What makes you sad?

What makes you happy?

What do you like most about yourself?

What do you wish you could change?

What do hope will happen or change because of therapy?

What else might be important for me to know in order to best help you?

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CHECKLIST OF CONCERNS – Please identify any concerns that you feel apply to you, and provide any comments.

CONCERN	COMMENT
☐ Anger Difficulties	
☐ Anxiety / Worries	
☐ Attention Difficulty	
☐ Body Image	
☐ Conflicts Family/Friend	
☐ Depression/Sadness	
☐ Drug/Alcohol/Smoking	
☐ Eating Issues	
☐ Fears / Phobias	
☐ Friendship Problems	
☐ Gender Identity	
☐ Irritability	
☐ Legal Problems	
☐ Loneliness	
☐ Medical Problems	
☐ Mood Swings	
☐ Nervousness	
☐ Nightmares	
☐ Obsessive Thoughts	
☐ Panic Attacks	
☐ School Problems	
☐ Self Harm	
☐ Sexual Activity	
☐ Sleep Problems	
☐ Shyness	
☐ Suicidal Thoughts	

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