

Macomb Family Services, Inc.

Age 17 & Under-Client Self-Report

Case No: _____

Client Name: _____ Date: _____

Client Social Security #: _____

Form completed by (if someone other than client) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home) _____ (Work) _____ DOB ___ / ___ / ___ Age _____

May the agency/therapist contact you at home? Yes ___ No ___ Work? Yes ___ No ___

Why are you requesting counseling? When did these issues start?

Symptom Checklist: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sleep related disorders |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Impulse control | <input type="checkbox"/> Past substance use/abuse |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Lack of interest in activities | <input type="checkbox"/> Current substance use/abuse |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Suicidal/Homicidal ideations |
| <input type="checkbox"/> Difficulty adjusting to life changes | <input type="checkbox"/> Loss/Grief | <input type="checkbox"/> Tearful |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Mania | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Distinctive behaviors | <input type="checkbox"/> Nightmares/Night terrors | <input type="checkbox"/> Worrisome |
| <input type="checkbox"/> Fire-setting | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Oppositional behaviors | |

If you have other symptoms not listed above, please describe.

Have any of the above symptoms been present for more than a year?

What improvements would you like to see?

Personal: _____

Family: _____

Social: _____

School: _____

COUNSELING AND PRIOR TREATMENT

Please list all previous treatment experiences.

Type of Treatment	Yes	No	Date (month/year)	# Of times	Where	Outcomes
Counseling/Psychiatric Treatment						
Alcohol/Drug Treatment						
Hospitalizations						
Self-help groups: AA, Al-Anon, ACOA, Overeaters, Other(s) _____						

Have you experienced any of the following?

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|
| Current | Past | No | | Current | Past | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Problems in school |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trauma from crime |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional difficulty due to divorce |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neglect | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sibling conflicts |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Protective Service Involvement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Parenting problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe childhood illnesses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Physical / Domestic violence |

Describe Incident	When

Have you ever experienced any suicidal thoughts? Yes No Current Past Age: _____
 If yes, please describe; and if they are current, please provide some details.

Have you ever attempted suicide? Yes No Current Past Age: _____
 If yes, list how many times, the most recent date, and the method (s) used.

Have you experienced any homicidal thoughts? Yes No Current Past Age: _____
 If yes, please describe; and if they are current, please provide some details.

Have you ever acted on these thoughts? Yes No
 If yes, list how many times, the most recent date, and the method (s) used.

Have you ever assaulted anyone? Yes No
 If yes, list how many times, and include the dates and how the assault(s) happened.

Has a family member or close friend of yours ever attempted or committed suicide? Yes No

Family Member or Friend	Attempted / Committed	When / Age

PHYSICAL & MEDICAL HISTORY

Last physical exam: Date: _____ Performed by: _____

Address of Personal Physician _____

_____ Telephone No. _____

Do you have any history of head injuries? Yes No If yes, at what age: _____

Are you pregnant? Yes No If Yes, when is your expected due date: _____

How would you describe your health? Excellent Good Fair Poor

Have you ever had any seizures? Yes No If Yes, when _____

Have you ever had surgery? Yes No If Yes, when: _____

Do you have access to medical insurance? Yes No

I currently receive treatment for physical symptoms, pain, and/or an impairment or disability. Yes No

Please list any past or present illnesses or medical conditions (Type of Illness or Condition)	Are you currently being treated?	
	YES	NO

Do you have any known drug or other allergies? Yes No

If Yes, please list: _____

Have you experienced or been treated for any of the following problems? Yes No

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> TB |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Weight Changes |
| <input type="checkbox"/> DT's | <input type="checkbox"/> Pancreatis | <input type="checkbox"/> Other |

If Other, please list: _____

Please list your current medications, including over the counter (OTC) medications.

Medication	Dosage	RX Date	Doctor	Reason

Is there any family history of medical issues? Yes No

If Yes, please list: _____

FAMILY INFORMATION

	Name	Current Age	Deceased		Your age then	Living with you	
			Yes	No		Yes	No
Mother							
Father							
Spouse							
Children							
Siblings							

Please list anyone else living with you.

	Age	Relationship to you

Parental Information:

- Parents legally married: how long _____
- Parents ever separated: your age _____
- Parents ever divorced: your age _____
- Mother remarried: your age _____
- Father remarried: your age _____
- I was adopted and/or placed in foster homes. , your age _____

Do you have any conflicts with family members? Yes No

If Yes, Please explain: _____

How would you describe your current relationships with family: Good Fair Poor

Please list any other family information that your therapist may find helpful in treating you. For example, were you raised outside the home by grandparents, other family members, or foster homes, etc?

Describe how you relate to other people (e.g., easily, shy, leader, follower, outgoing, etc.)

Who are the (3) people you feel closest to? _____

Do you wish to have any family members or close friends involved in your treatment? Yes No

Marital Status:

- Single
- Unmarried & living with significant other
Length of time _____
- Married, age when married _____
Length of time _____
- Divorced, age when divorced _____
Length of time _____
- Widowed, age when widowed _____
Length of time _____

Other Marital Information: (check all that apply)

- Total number of marriages _____
- Separated
Length of time _____
- Divorce in progress
- Annulment
Length of time _____

Assessment of current relationship: Good Fair Poor N/A

Has anyone in your family ever been diagnosed with a mental illness? Yes No

Family Member	Type of Illness	When

RECREATION & LEISURE

Has your activity level changed in the last 6 months? Yes No

If yes, please describe: _____

Which of the following activities do you participate in on a regular basis?

- | | |
|---|---|
| <p>Daily/ Weekly/ Monthly</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Art <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Music <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crafts <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Outdoor activity <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Church activity | <p>Daily/ Weekly/ Monthly</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Books/Films <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physical Fitness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diet/Health <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sports <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other _____ |
|---|---|

Do you or any family member have a gambling problem? Yes No

Do you ever gamble more than you intended? Yes No

If yes please describe _____

SPIRITUAL & RELIGIOUS MATTERS

If yes to the above what religion were you raised in and what religion to you practice now?

Do you have any spiritual/religious issues that may affect your treatment? Yes No

If yes, explain _____

CULTURAL / ETHNIC INFORMATION

What is your cultural or ethnic background? _____

Is your cultural or ethnic background a significant part of your life? Yes No

If yes, explain _____

Do you have any concerns how your culture or ethnicity may affect your therapy? Yes No

If yes, explain _____

SUPPORTS / STRENGTHS / SOCIAL

Who do you feel you can look to for support? _____

If you were in need of help, or needed to talk to someone, who would you turn to?

Do you feel that family members support each other? Yes No

If no, explain _____

Describe how you relate to other people (e.g., easily, shy, leader, follower, outgoing, etc.)

Please list your strengths: _____

Who are the (3) people you feel closest to? _____

Do your social activities include the use of drugs or alcohol? Yes No If yes, please explain:

Sexual Orientation:

___ Heterosexual (attracted to opposite sex)

___ Bisexual (attracted to both sexes)

___ Homosexual (attracted to the same sex)

___ Confused / Not sure

Do you have concerns about your sexuality that you would like to discuss with your therapist?

Yes No If yes, please

explain. _____

EDUCATION

Did your child attend a pre-school or day-care program? Yes No

When? _____ How long did he or she attend? _____

Where does your child attend school? _____

Teacher's Name _____

Grade _____ Current grade average (A-F) _____ Any recent changes? _____ Up Down

Were any grades repeated? Yes No If Yes, what grade (s)? _____

Has your child ever had special tutoring? Yes No Type: _____

Has your child ever attended special education classes? Yes No Type: _____

How would you rate your child's relationship to his/her teacher(s)? Excellent Good Fair Poor

Has your child ever been suspended/expelled from school? Yes No

When? _____ For how long? _____

How many different schools has your child attended? _____

How would you rate your child's behavior in school? Excellent Good Fair Poor

LEGAL

Have you been referred to **MFS** by Court Order? Yes No

Have you been referred to **MFS** by DHS? Yes No Worker's Name _____

Name & Address of court (if applicable) _____

Have you ever been, or are you now involved in any of the following legal or court proceedings?

Drunk Driving Yes No Currently on Probation/Parole Yes No

Assault Crime Yes No Civil Case Yes No

Workman's Comp Yes No Juvenile Court Yes No

Bankruptcy Yes No DHS Yes No

If yes please complete the following:

Type of Case, charge, arrest, etc.	Date	Where (city)	Result

If yes, explain _____

COMPULSIVE BEHAVIOR

Have you experienced any of the following behaviors that you would consider compulsive or addictive.

- | | | |
|-----------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Internet | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Pornography | <input type="checkbox"/> Work |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Sex | <input type="checkbox"/> Other |

Comments:

CHEMICAL USE HISTORY

Has your child's social activities included the use of drugs or alcohol? Yes No

If yes, explain: _____

Do you suspect a drug/alcohol problem? Yes No

What is the drug of choice? _____ When was a substance last used? _____

How much is, or was being used? _____ Longest period of abstinence? _____

Please complete the following table as it relates to your child.

Child's Current Age _____	Age of first use	Age of last use	Method of use				Amount	How Often?	Used in last 48 hours		Used in the last 30 days	
			Oral	Injection	Smoke	Inhale			Yes	No	Yes	No
Caffeine												
Nicotine												
Alcohol												
Barbiturates												
Valium / Librium												
Cocaine/Crack												
Heroin/Opiates												
Marijuana												
PCP												
LSD												
Mescaline												
Inhalants												
Ecstasy												
Crank/Ice												
Other												

Please check all that may apply to your child.

- | | |
|---|---|
| <input type="checkbox"/> Drinking/drug use before school | <input type="checkbox"/> Skipping class to get high |
| <input type="checkbox"/> Family/friends concerned about use | <input type="checkbox"/> Using during school hours |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Binge use |
| <input type="checkbox"/> Found evidence of alcohol/drug use at home | <input type="checkbox"/> Behavior changes |

Do any of your family members have a drug or alcohol problem? Yes No

If so, whom? _____

Would you like more information regarding the prevention of alcohol & drug use/abuse? Yes No

NUTRITIONAL PATTERNS

Height: _____ Weight: _____ Are you on a special Diet? Yes No

What kind? _____ Why? _____

When was the last time you exercised? _____

Do you eat less than three meals per day? Yes No

Do you binge eat? Yes No

If yes, describe: _____

Has your weight changed by more than 10 pounds in the past year? Yes No Up Down

If yes, how much? _____

Do you have any concerns about your eating patterns? Yes No

If yes, explain _____

BIRTH / DEVELOPMENT INFORMATION

Birth History:

- | | | |
|--|--|--|
| <input type="checkbox"/> Normal Pregnancy | <input type="checkbox"/> Premature labor and delivery | <input type="checkbox"/> Normal APGAR scores at birth |
| <input type="checkbox"/> Normal labor and delivery | <input type="checkbox"/> Trauma/illness during pregnancy | <input type="checkbox"/> Post-natal respiratory difficulties |
| <input type="checkbox"/> Born with Disability | <input type="checkbox"/> Limited or no prenatal care | <input type="checkbox"/> Post-natal motor difficulties |
| <input type="checkbox"/> Routine prenatal care | <input type="checkbox"/> Substance use during pregnancy | <input type="checkbox"/> Extended hospital stay |

Were there any other post-natal difficulties: Yes No

If yes, what kind? _____

Did child go home with mother from hospital? Yes No

My child reached their developmental milestones at the correct age? Yes No

Question (please answer the following questions to the best of you ability) At what age did your child achieve the following?	Age
Hold their head held erect and steady.	
Roll Over	
Sitting Up	
Crawling	
Walking	
First Words	
Sentences	
Toilet-trained - day	
Toilet-trained - night	

Medical History

Question (please answer the following questions to the best of you ability) Has your child ever experienced any of the following?	Yes	No
Head Injury or trauma		
Hyperactivity		
Hypoactivity		
Headaches		
Significant Injury		
Seizures		
Hospitalization		
Significant Illness		
Surgery		
Hearing problems		
Vision problems		
Speech problems		

Are your child's immunization records up to date? Yes No

MMR: Yes No Age: _____

Tetanus: Yes No Age: _____

Poliomyelitis: Yes No Age: _____

Whooping Cough: Yes No Age: _____

Smallpox: Yes No Age: _____

SOCIAL

Peer Relations

How would you describe your child's relationship with peers?

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Appropriate | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Leader |
| <input type="checkbox"/> Conflictual | <input type="checkbox"/> Violent | <input type="checkbox"/> Gang Association |
| <input type="checkbox"/> Bossy | <input type="checkbox"/> Argumentative | <input type="checkbox"/> Other |
| <input type="checkbox"/> Passive | <input type="checkbox"/> Follower | |

Relationships with Adults or Authority Figures

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Appropriate | <input type="checkbox"/> Passive | <input type="checkbox"/> Leader |
| <input type="checkbox"/> Conflictual | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Gang Association |
| <input type="checkbox"/> Isolated | <input type="checkbox"/> Violent | <input type="checkbox"/> Loner |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Argumentative | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bossy | <input type="checkbox"/> Follower | |

If other, Please comments:

Is the Child or adolescent sexually active? (as reported by client):

- Yes No Refused to answer

Has the child ever been alleged, suspected, or charged w/behavior of a sexual nature?

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Fondling | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Peeping | <input type="checkbox"/> Oral Sex/Sodomy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Inappropriate Touching | <input type="checkbox"/> Intercourse | |

If other, Please comments:

Has your child ever received Psychological Testing? Yes No

When: _____ Where: _____

Client Signature _____ Date _____

Parent/Legal Guardian _____ Date _____

Therapist Signature/Credentials _____ Date _____

