Portland Dialectical Behavior Therapy Program, PC
Self-Report Form

Name: ____________________________ **Date:** _________________

Please check items that you consider problematic:

☐	Distractibility	☐	Panic attacks	☐	Impulsivity	☐	Reoccurring nightmares
☐	Sadness/depression	☐	Fear of being away from home	☐	Compulsive behavior	☐	Intrusive thoughts/images
☐	Hopelessness	☐	Anxiety/worry	☐	Hyperactivity	☐	Sleep difficulties
☐	Sleep problems	☐	Obsessive thoughts	☐	Irritability/anger	☐	Hypervigilance
☐	Change in appetite	☐	Flashbacks	☐	Aggression/fights	☐	Flashbacks
☐	Loss of pleasure	☐	Nightmares	☐	Frequent arguments	☐	Avoidance of trauma related stimuli
☐	Crying spells	☐	Social discomfort	☐	Sexual Problems	☐	Increased startle response
☐	Seasonal mood changes	☐	Suspicion/paranoia	☐	Computer addiction	☐	Feeling detached/dissociation
☐	Thoughts of death	☐	Visual hallucinations	☐	Relationship problems	☐	Other:
☐	Low self worth	☐	Racing thoughts	☐	Problems with pornography	☐	
☐	Fatigue	☐	Hearing voices	☐	Gambling problems	☐	
☐	Withdrawal from people	☐	Poor memory/confusion	☐	Work/school problems	☐	
☐	Guilt/Shame	☐	Homicidal thoughts	☐	Eating problems	☐	
☐	Lack of motivation	☐	Self-harm	☐	Parenting problems	☐	
☐	Wide mood swings	☐	Loneliness	☐	Alcohol/drug use	☐	
☐	Excessive energy	☐	Boredom	☐	Other:	☐	

Additional symptoms or problems:

Previous or current diagnoses:

Please check areas that are affected by the above items:

☐Hygiene	☐Finances/ housing	☐Sexual activity	☐Recreational activities
☐Relationships	☐Work/school	☐Health	☐Handling daily tasks

History of problem:

Time period	**Details of problem**
Childhood	
Adolescence	
Young adulthood	
Other:_____________	

Current treatment: ☐ **No current treatment**

Provider	Name	Contact information	Summary of treatment (e.g. length of time, progress thus far)
Current therapist			
Current prescriber			
Current treatment programs			
Community resources			

Previous treatment and outcome: ☐ **No previous treatment**

Provider/program	Dates seen	Outcome

Hospitalizations: ☐ **No hospitalizations**

Hospital	Dates	Reason

High risk behavior:

Suicidal ideation ☐ No suicidal ideation

☐	Severe suicidal ideation
☐	Moderate suicidal ideation
☐	Mild suicidal ideation
☐	Frequent non-suicidal thoughts about death or other morbid thoughts
☐	Current plan for suicide including timeline. Details:
☐	Gun in home

Suicide attempts ☐ No attempts

Suicide attempt (date/age)	Circumstances?	Treatment received

Self-harm behavior ☐No self-harm behavior

Self-harm behavior	☐Current ☐Past
Type of self harm behavior	☐Cutting ☐Burning ☐Overtaking medications ☐ Hitting self ☐Scratching ☐Other:
Circumstances?	

Aggressive behavior ☐No aggressive behavior

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

Legal history: ☐**No legal history**

☐On probation	☐ Convicted of felony	☐Involved in custody case	☐Legal charges
Number of arrests:	☐Convicted of misdemeanor	☐ Involved in divorce	☐ DUII

Addictive behavior: ☐**No alcohol/drug use**

Current substance use	☐Alcohol ☐Marijuana ☐Cocaine ☐Methamphetamines ☐Ecstasy ☐Heroin ☐Inhalants ☐LSD ☐Steroids ☐Prescription medications, Type:
Quantity of use	Frequency of use: Amount used:
History of substance use	Details:
Current or past gambling	Details:
Previous treatment	☐Outpatient ☐Residential ☐IOP
Family history	☐Father ☐Mother ☐Siblings ☐Grandparents ☐Aunts/Uncles ☐Cousins ☐Other:

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

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

Do you ever have problems with work, relationships, health, the law, etc. due to your substance use?
☐No ☐Yes, details:

Trauma: ☐ **No trauma**

Trauma	☐ Current ☐ Past
Type of trauma	☐ Sexual abuse ☐ Physical abuse ☐ Emotional abuse ☐ Neglect ☐ Other:
Circumstances?	

Medical status:

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

Current prescription medications ☐ No prescription medications

Medication	Dosage	Duration	Prescribed by

Is there anything else you want your therapist to know about you?

What are your goals for treatment?