

Student Self-Referral Form for Mental Health and Counseling Support

Name	Grade Level	Gender	Date Form Completed
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Are you a special education student? Yes No

How urgent is your request for counseling?

Not Urgent Moderately Urgent Very Urgent
 1 2 3 4 5 6 7 8 9 10

Please check as many of the following that may apply to your situation:

FEELINGS ...

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Really sad | <input type="checkbox"/> Grief | <input type="checkbox"/> Withdrawn/isolated | <input type="checkbox"/> Hostile/unapproachable |
| <input type="checkbox"/> Hopeless | <input type="checkbox"/> Extremely afraid | <input type="checkbox"/> Very distracted | <input type="checkbox"/> Self-esteem problems |
| <input type="checkbox"/> Worthless | <input type="checkbox"/> Irritable | <input type="checkbox"/> Depressed | |
| <input type="checkbox"/> Very angry | <input type="checkbox"/> Always crying | <input type="checkbox"/> Out of control | |
| <input type="checkbox"/> Anxious/worried | <input type="checkbox"/> Rejected by peers | <input type="checkbox"/> Always tired/sleepy | |

BEHAVIORS ...

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cutting/scratching self | <input type="checkbox"/> Using drugs/alcohol | <input type="checkbox"/> Skipping school | <input type="checkbox"/> Thoughts of death |
| <input type="checkbox"/> Eating then vomiting | <input type="checkbox"/> Suicidal thoughts/threats | <input type="checkbox"/> Bizarre thoughts | <input type="checkbox"/> Sudden weight loss |
| <input type="checkbox"/> Not eating | <input type="checkbox"/> Grades falling | <input type="checkbox"/> Destroying property | <input type="checkbox"/> Abusive/fighting |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Disrupting class | <input type="checkbox"/> Excessive absences/tardy | |

OTHER ...

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Physical assault | <input type="checkbox"/> Difficulty with parent | <input type="checkbox"/> Always sick/tired |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Death of family/friend | <input type="checkbox"/> Negative peer influence |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Family drug/alcohol use | <input type="checkbox"/> Parents separated/divorced | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Rape (stranger/date) | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Relationship problems | |

Have you spoken to anyone about any of the above? Yes No

If yes, who? Teacher Parent/guardian Principal/administrator House parent School nurse
 Other:

Are you over the age of 12? Yes No

If you are over the age of 12, do you have any concerns about your parents/guardian being contacted to consent to you receiving mental health services? Yes No

By law, reports that may indicate abuse or neglect may have to be referred to the Child and Family Services Agency. See the mandated reporting protocol or consult with a member of the school-based mental health team for more information.

PLEASE RETURN COMPLETED FORMS TO YOUR SCHOOL MENTAL HEALTH COORDINATOR.