Please answer the following questions as accurately and honestly as possible. If you have a problem with a question, feel free to skip it and bring it up in person with me. This assessment will give us a much clearer picture of your current situation and where we should start. Please remember that all answers are confidential and are covered by our confidentiality agreement. Thank you for taking the time to complete this form.

Identification and Presenting Problem

Name:_____ Today's Date:_____

Age:_____ Birth date:_____ Where were you born?_____

Who referred you to me?_____

Cultural or ethnic background? _____

The problem I want help with is:_____

_____

_____

_____

Physical/Medical Health

I would rate my overall physical health as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

Name of Primary Care Physician_____ Date of last visit_____

Do you see any other doctors? Yes ❑ No ❑ if yes, who and for what?_____

_____

List all current medications	Dosages	Reason for medication

How many times, when, and for what have you been hospitalized for medical problems in the last 5 years?

_____

_____

_____

_____

Yes	No	Do you have or have you ever had: (circle those that apply and write in others)
		Eye, ear, nose, throat problems: glaucoma; lens implants; dentures, loose teeth, dental caps or bridges; wear hearing aids, glasses, contacts or artificial eye
		Heart problems: chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pace maker, defibrillator
		Vascular problems: high blood pressure, blood cots
		Lung problems: asthma, emphysema, tuberculosis, coughing, coughing blood, sleep apnea
		Gastrointestinal problems: hepatitis, cirrhosis, ulcers, hiatal hernia, intestinal bleeding, vomiting/diarrhea within the last 24 hours
		Genitourinary problems: OB/GYN, kidney disease/failure, prostate problems, incontinence, sexually transmitted diseases, infections
		Musculoskeletal problems: back problems, broken bones of neck/back/face, limited range of motion, arthritis, TMJ
		Skin problems: rash, hives, bruise easily, open sores
		Neurological problems: seizures, paralysis/numb areas, stroke, weakness, migraines, confusion
		Endocrine problems: diabetes, thyroid
		Cancer:
		Head injury:
		Possibility you could be pregnant? Approximate due date?
		Allergies To what?

Any other physical or medical health issues not asked above?_____

_____

Do you exercise? Yes ❑ No ❑ if yes, how many days per week: 1 2 3 4 5 6 7

What do you do?_____

Have you ever injected any substance into your body? Yes ❑ No ❑ if yes, what?_____

Have you ever had unprotected sex that may have put you at risk for infectious diseases? Yes ❑ No ❑

Do you own any guns? Yes ❑ No ❑ if yes, are they secured from children? Yes ❑ No ❑

Mental, Emotional and Psychiatric Health

Note: When answering the following questions, please consider only those times when you have not been under the influence of alcohol or drug(s) (i.e. marijuana, cocaine, heroin, methamphetamines, LSD, etc.) with the exception of cigarettes.

Please answer the following questions about your mental/emotional health…		
Yes	**No**	**Section 1**
		Have there been times in your life that you have felt sad, low, or hopeless? How long did it last? Greater than 2 weeks ❑ or less than 2 weeks ❑ The last time I felt depressed was?
		Did you have problems with getting to sleep, staying asleep, or getting up too early?
		Did you have problems with your appetite? (eat too much or too little)
		Did you gain or lose more than 10-20 Lbs?
		Did you feel tearful or cry a lot?
		Did you have feelings of worthlessness and hopelessness?
		Have you ever felt so bad you wanted to hurt yourself or end your life?
		Have you ever attempted suicide? If yes, how many times and when?
Yes	**No**	**Section 2**
		Have there been times in your life that you have felt unusually high or charged-up?
		Did this increase in energy last more than one week? **If NO go to next section**
		Did your sleep patterns change because of this energy?
		Did your family or friends tell you that you were too excited, revved-up or talkative?
		Did you feel euphoric, irritable, or anxious at that time?
		Did you do anything unusual or impulsive at that time?
Yes	**No**	**Section 3**
		Have you ever felt that others wanted to hurt you or get you for some reason?
		Have you seen things or heard things that others have not seen or heard?
		Has the television or radio ever sent you personal or private messages?
		Did you feel that other people can insert, withdrawal, or control your thoughts?
Yes	**No**	**Section 4**
		Do you feel you are an anxious or worrisome kind of person?
		If yes, does this nervousness keep you from going out of your house (shopping, dining out)?
		Do you have any strong fears or phobias? What are they?
		Are there times in which you become fearful or anxious without apparent reason?
		If yes, what is the frequency and duration of these episodes?
		Have you ever had a panic attack? How often?
		Have you ever felt that you had to do things repeatedly though you just had done them? (checking, counting, washing, or other activities multiple times in a day)
		Have you ever had thoughts stick in your head, even ones that make no sense?
		Have you ever had flashbacks or nightmares in which you relive an upsetting past event?
		Have you ever experienced any type of trauma in your life? (physical, sexual, emotional)

Yes	No	Section 5
		As a child were you more active or restless than the other children?
		Did you have problems sitting still or paying attention?
		Were you told that you day dreamed a lot?
		Were you the class clown?
		Did friends or family call you hyperactive?
		Did you received poor grades in grade school?
		Do you now feel like your life is moving 90 miles per hour while everone else is going 55 mph?
		Have you ever been medicated for hyperactivity
Yes	**No**	**Section 6**
		Have you ever used laxatives or diuretics to control your weight?
		Have you ever made yourself throw-up or starved yourself because you thought you were fat?
		Have you ever lost so much weight that others were worried about you?
		Have you ever felt fat when others told you that you were thin?

Substance Use/Abuse/Addiction

Have you ever used these drugs? (**check all that apply**)		Age of first use	Date of last use (can estimate)	Longest sobriety in the last 30 days (in days)	Longest sobriety in the last 10 years
Alcohol					
Bath Salts					
Club Drugs					
Cocaine					
E-Cigarettes					
Hallucinogens LSD, peyote					
Heroin					
Inhalants Gas, glue, rush					
K2/Spice					
Marijuana/Hash					
MDMA Ecstasy/Molly					
Methamphetamine					
Prescription Drugs Pain Medicine, ADHD					
Salvia LSD, peyote, etc.					
Steroids (Anabolic) heroin, opium, codeine					
Tobacco/Nicotine					
Other: Please List					

List all substances used in the last year	Average days per month you use substance	Average quantity per day (drinks, grams, # of pills, etc.)	How do you get it into your body? (drink/smoke/IV)
1.			
2.			
3.			
4.			
5.			
6.			

Note: Include pain medication, over the counter drugs, or any other prescription medication if used in any way other than prescribed.

Behavioral/Process Addictions

Like substances, we know that behaviors can also become very compulsive or addictive for people. Do you believe that you have engaged in any of the following behaviors in a compulsive or addictive manner?

Behavior	Examples	1 = no problem 10 = big problem
Eating (food)	eating to deal with negative moods, eating more than intended, etc…	1 2 3 4 5 6 7 8 9 10
Sex	compulsive masturbation, pornography, prostitution, voyeurism, etc…	1 2 3 4 5 6 7 8 9 10
Gambling	compulsive video poker, scratch-offs, chasing losses, etc…	1 2 3 4 5 6 7 8 9 10
Spending	high debts, spending to deal with negative moods, etc…	1 2 3 4 5 6 7 8 9 10
Internet	chat rooms, pornography, long hours, loss of time, isolation, etc…	1 2 3 4 5 6 7 8 9 10
Exercise	over train body, major change in moods when not exercising, etc…	1 2 3 4 5 6 7 8 9 10
Other	Please write in:	1 2 3 4 5 6 7 8 9 10

For any behavior you marked "**5**" or greater, please provide details about specific behaviors, frequency, and why you believe it may be a problem:_____

_____

_____

_____

_____

_____

Education

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

University / College / Trade School / Other:_____ (circle all that apply)

Degree(s)_____ What field(s)?_____

Currently enrolled in school? Yes ❑ No ❑ if yes, where?_____

Past/Present problems in school? Yes ❑ No ❑ (if yes, circle all that apply) failing grades / suspensions school changes / reading / writing / math / understanding the teacher / cooperating with other students

How do you learn best? ❑ Visual – learn through reading, seeing things, graphics, illustrations

❑ Auditory – learn by hearing information, listening to tapes, music

❑ Tactile – learn by touching things, feeling in the body, movement

Employment/Financial Situation

Employed? Yes ❑ No ❑ if yes, where?_____

How long?_____ Job title or duties:_____

If not employed, please explain (include being disabled):_____

_____

Have you had trouble keeping jobs? Yes ❑ No ❑ if yes, why do you think so?_____

_____

Trouble with current job (circle all that apply): absenteeism / tardiness / boredom / decrease in performance arguments with other employees / not challenged / burned-out / stress / sexual harassment / other:_____

_____

Has your income changed a lot during the past two years? Yes ❑ No ❑ How? Gone up / Gone down

Do have any financial difficulties? Yes ❑ No ❑ if yes, please explain:_____

_____

Legal

Have you ever been arrested? Yes ❑ No ❑ if yes, how many times?_____ **if no, go to next section**

Number of arrests in the last two years?_____ Charges:_____

Total number of DUII's:_____ Total DUII's in the last 5 years:_____ Date of last one:_____

How many days/months have you spent in jail or prison in your lifetime:_____

What have you been arrested for (circle all that apply): alcohol & drug offenses / crimes against people domestic violence / sex crimes / restraining order / crimes against property (burglary/theft) / Other (list):

_____

Are you currently involved in the legal system? Yes ❑ No ❑ if yes, what is your status?_____

_____

Are you mandated to be in treatment? Yes ❑ No ❑ if yes, by who?_____

Spiritual

My family's religious denomination preference was / is:_____

My current religious denomination preference was / is:_____

My current religious or spiritual practices include (prayer, church, meditation, etc.):_____

_____

Do you believe spiritual/religious issues relate to your current problems? Yes ❑ No ❑ if yes, explain:____

_____

Sexual

My sexual orientation/gender is: Male ❑ Female ❑

How do you label yourself (circle): Heterosexual / Bisexual / Homosexual / Asexual / Don't know

I am presently in a one-person relationship? Yes ❑ No ❑ if yes, how long?_____

Sexually active? Yes ❑ No ❑ Never ❑

If yes, how many partners in the past six months (circle): 1 2 3 4 5 +

Any current problems with sex that should be addressed in treatment?_____

_____

Military

Military Service? Yes ❑ No ❑ if yes, are you currently serving? Yes ❑ No ❑

Branch:_____ Discharged: Honorable / General / Medical / Dishonorable (circle one)

Dates served:_____ I had problems in the military related to addiction: Yes ❑ No ❑

I have participated in combat zone military actions: Yes ❑ No ❑ if yes, please describe:_____

_____

Treatment History

Have you ever been in treatment, seen a counselor or other helping health care professional for problems related to alcohol, drugs or other addictions? Yes ❑ No ❑ if yes, total number of treatment episodes?_____

Have you ever had counseling or psychiatric treatment for a mental health problem(s)? Yes ❑ No ❑

Are you currently seeing a psychiatrist, psychologist or other mental health professional? Yes ❑ No ❑

If yes, who and for how long?_____

Do you have a mental health diagnosis? Yes ❑ No ❑ if yes, what?_____

Name of treatment program, or type of therapist	Year	How Long	For problems related to:
Example: Psychologist	*2000*	*Six months*	*Alcohol abuse, depression, marriage problems*
1.			
2.			
3.			
4.			
5.			
6.			

Have you been to detoxification centers for use of alcohol or drugs? Yes ❑ No ❑ if yes, how many?_____

Any participation in 12-step programs (AA, NA, SAA, GA)? Yes ❑ No ❑ if yes, which programs and for how long?_____

Overall feeling about 12-step programs?_____

_____

Social – Living Environment

I currently live in: house / apartment / trailer / rent room / mission / car / street / Other:_____

How long?_____(years/months) With whom do you live?_____

_____

Are you satisfied with current living situation: Yes ❑ No ❑ if no, explain:_____

Number of times I have moved in the last five years:_____ Were moves related to current problems:_____

Number of close friends I have:_____ Number of friends I see in person at least once per week:_____

Who provides you the most emotional support?_____

For support do you turn to (circle all that apply): spouse or significant other / family / friends / self-help groups church / employer / spirituality or religion / Other:_____

What do you do for fun?_____

_____

_____

Please check any of the following barriers for you to come to therapy at this time:

Distance	❑	Literacy	❑
Mobility impairment	❑	Housing	❑
Childcare responsibilities	❑	Financial	❑
Transportation	❑	Language	❑

Family - Past

For the following section, please list all members of your family of origin, including step-parents, foster parents, step-siblings, or extended relatives if they played a primary role in your life growing-up.

Family Member Name	Relation	Alcohol, drugs or other addictions?	Mental health problems
Example: David Smith	*Father*	*Yes, alcohol and gambling*	*depression*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

When growing up I lived with?_____

Parents occupation?_____

My mother was: good / religious / smart / loving / critical / demanding / cold / warm / bad / sick / absent / inadequate / kind / harsh / distant / nurturing / Other:_____

My father was: good / religious / smart / loving / critical / demanding / cold / warm / bad / sick / absent inadequate / kind / harsh / distant / nurturing / Other:_____

I moved_____times before the age of 18. (please insert number of times)

Family - Current

I am: single / married / separated / divorced / widowed / in a committed relationship (please circle one)

How long?_____ If married, married to 1st / 2nd / 3rd / 4th spouse (please circle one)

Is your spouse/partner employed? : Yes ❑ No ❑ if yes, where:_____

Names of biological children	Age	Any problems or issues? (substance abuse, mental health)
Names of step-children	Age	Any problems or issues?

I would describe my family life as: peaceful / fighting / loving / angry / warm / distant / caring / selfish calm / tense / enjoyable / difficult / rewarding / irritating / other:_____

End of questionnaire - thank you for taking the time to complete this evaluation information!

SUMMARY – TO BE COMPLETED BY THERAPIST – PLEASE LEAVE BLANK

Mental/Emotional/Psychiatric Issues

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Substance or Behavioral Addiction Issues

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Physical or Medical Health Issues

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Environmental Issues (social/legal/financial/etc.)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Other:_____

_____

_____

_____

_____

_____

_____