Client’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Male Female

Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lives With\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Areas of Difficulty** (Check all that apply. If not checked, we will assume there is no problem.)

Marriage/Relationships/Family Ability to Concentrate

Job/School Performance Ability to Control Temper

Disability Leave Hobbies/Interests/Play Activities

Job/School Jeopardy Eating Habits

Sleeping Habits Weight Gain in past 6 months\_\_\_\_\_\_\_\_

Difficulty Falling Asleep Weight Loss in past 6 months\_\_\_\_\_\_\_\_

Difficulty Staying Asleep Current Weight\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_

Early Morning Awakening Friendship/Peer Relationships

Financial Problems Sexual Function

Activities of Daily Living (personal hygiene, bathing, etc.) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms** (Check all that apply. If not checked, we will assume there is no problem.)

Depressed Mood Irritability Stealing

Decreased Energy Impulsiveness Bedwetting/Pooping

Grief Hyperactivity Setting Fires

Intellectual Deficit Disruption of Thoughts Running Away

Guilt/Low Self-Esteem Delusions Learning Disability

Lying Hallucinations School Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hopelessness/Helplessness Memory Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiousness Panic Attacks Medical Conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obsessions/Compulsions Defiance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma: Emotional/Verbal/ Physical Complaints: Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical/Sexual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Victim \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interested in Losing Weight

Perpetrator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interested in Quitting Smoking

**Treatment History**  No Previous Treatment

Inpatient

Outpatient past year One prior admission Multiple admissions

Psychiatric

Substance Abuse

**Substance Abuse History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type** | **Amount** | **Frequency/Pattern** | **Method of Use** | **Last Use** | **Age of 1st Use** |
| Alcohol |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Heroin/Narcotics |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Cocaine/Crack |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |
| Nicotine |  |  |  |  |  |
| Barbiturates |  |  |  |  |  |
| Other |  |  |  |  |  |
| Addictions (gambling/sex) |  |  |  |  |  |

**Symptoms of Dependence**

Nausea/Vomiting/Diarrhea Black-outs

Aggressiveness Inappropriate Behaviors

Strong Urge to Use Auditory/Visual Hallucinations

Consequences of Substance Use Longest Period of Abstinence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Development of Tolerance Family History of Chemical Dependency

Withdrawal Symptoms (seizures, cravings, DT’s, etc.)

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

Is the client on any prescribed medications, over-the-counter medications, or herbal or vitamin supplements?

No Yes (please complete medication information below)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **Purpose** | **Dosage** | **How Long on the Medication** | **Prescriber** | **Is it helpful?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Do you have a good understanding of your medications and how they work? Yes No

**Social History** (check all that apply)

Current Marital Status: Employment Status: Number of Marriages\_\_\_\_\_\_\_

Married Full-Time Number of Dependents\_\_\_\_\_\_

Divorced Part-Time Highest Educational Level\_\_\_\_\_

Separated Self-Employed What school are you attending?

Living Together Disabled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Widowed Unemployed What kind of work do you do?

Single Retired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partnered Student

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family History** | **Mental Health** | **Substance Abuse** | **Developmental Delay** | **Major Medical** | **Criminal** | **Specify** |
| Grandparent |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |
| Siblings |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |