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

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

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

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**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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: |  |  |  |  |  |  |