**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Problem**

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

1. How long have you been experiencing this problem? [ ] Less than 30 days [ ] 1-6 months [ ] 1-5 years [ ] 5+ years
2. Rate the intensity of the problem (1 being mild and 5 being severe) \_\_\_\_\_\_\_\_\_\_
3. How is the problem interfering with your day-to-day functioning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How do you think we can best help you today?

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

**Mental Health History**

Yes No NA

1. Have you received mental health services in the past? [ ] [ ] [ ]
2. If yes, whom did you see and when?

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

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1. Is there a family history of mental problems in your family? [ ] [ ] [ ]
2. If yes, please describe
3. Have you ever been in the hospital for the treatment of mental illness? [ ] [ ] [ ]
4. Are you currently prescribed any medications for mental health? [ ] [ ] [ ]
5. If yes, or if you have been on medications for mental health (prescribed, herbal or over the counter), please fill out the chart below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Is this a current or past medication | Length of time on medication? | List any side effects of the medication. | List any benefits of the medication. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Medical History**

Yes No NA

1. List any current or urgent health conditions or needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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1. Do you have health insurance? --------------------------------------------------------------------------- [ ] [ ] [ ]
2. Do you have a primary healthcare provider or receive regular medical care? [ ] [ ] [ ]
3. If yes, list healthcare provider contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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1. Are you currently prescribed any medications for general health issues?----------------------- [ ] [ ] [ ]
2. If yes, or if you have been on medications for general health issues (prescribed, herbal or over the counter), please fill out the chart below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Is this a current or past medication | Length of time on medication? | List any side effects of the medication. | List any benefits of the medication. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
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|  |  |  |  |  |  |

Yes No NA

1. Are you pregnant now? ------------------------------------------------------------------------------------- [ ] [ ] [ ]
2. If yes, when are you due? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you at risk for HIV/AIDS/STDS (unsafe sex, using needles?)-------------------------------- [ ] [ ] [ ]
4. Please list all allergies to medications or food:

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

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

1. Do you smoke cigarettes or use any form of tobacco? ---------------------------------------------- [ ] [ ] [ ]
2. If so, which and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religion:**

Religion: \_\_\_\_\_\_\_\_\_\_\_\_ Religious Beliefs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of involvement in religious activities: Daily \_\_ Weekly \_\_ Monthly \_\_\_ Holidays \_\_\_ N/A \_\_\_

Influence of Religion on life: Dominant \_\_\_ Important \_\_\_ Somewhat Important \_\_\_ Unimportant \_\_\_ N/A \_\_\_

**Spirituality: (Other than Religion)**

Importance of spirituality on life: Dominant \_\_\_ Important \_\_\_ Somewhat Important \_\_\_ Unimportant \_\_\_ N/A \_\_\_

Impact of Spirituality on Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spiritual Practices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Motivations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coping strategies for stress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnic History:**

1. Country of Origin or that of your family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Ethnic Composition of Neighborhood of Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Influence of Ethnic Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use History** (leave blank if not applicable)

Yes No NA

1. Do you now or have you ever drank alcohol or done substances? -------------------------------- [ ] [ ] [ ]

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Substance | Age first use | Amount of use | Frequency of use at Height | Method of use | Current frequency of use | Last date of use |
| Alcohol |  |  |  |  |  |  |
| Marijuana |  |  |  |  |  |  |
| Opioids |  |  |  |  |  |  |
| Benzodiazepine |  |  |  |  |  |  |
| Heroin |  |  |  |  |  |  |
| Cocaine / Crack Cocaine |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

1. Have you received substance abuse services in the past? ------------------------------------------[ ] [ ] [ ]
2. If yes, whom did you see and when?

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

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1. Is there a family history of substance or alcohol abuse problems in your family?--------------[ ] [ ] [ ]

If so, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently prescribed medication assisted treatment? -------------------------------------- [ ] [ ] [ ]

If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been arrested while under the influence? ------------------------------------------- [ ] [ ] [ ]
2. Has your substance use cause you to participate in illegal activities?--------------------------- [ ] [ ] [ ]
3. Has your substance use ever interfered with work or school?------------------------------------- [ ] [ ] [ ]
4. Has anyone ever told you that you may have a problem with drugs or alcohol?------------- [ ] [ ] [ ]
5. Has your substance use cause fights with family, friends or in relationships?----------------- [ ] [ ] [ ]
6. Have you ever tried to stop using on your own? How long did it last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. History of Self Help meetings? AA\_\_ NA \_\_ GA \_\_ DA \_\_ HA \_\_ SA \_\_ None \_\_ Other \_\_\_\_\_\_\_
8. Have you experienced any of the following withdrawal symptoms:

\_\_\_ Blackouts \_\_\_ D.T.s \_\_\_\_ Hallucinations \_\_\_\_ Tremors \_\_\_\_ Sweats \_\_\_Cravings \_\_\_ Seizures

\_\_\_ Irritability \_\_\_ Nausea \_\_\_ Vomiting \_\_\_Lack of Sleep \_\_\_ Violence \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Triggers for use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Background Information**

1. Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Where did you go to high school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What was the highest level of education you completed? [ ] Grade 8-12 [ ] GED/High School Diploma [ ] Some College [ ] College Degree [ ] Master’s Degree
4. Would you describe your school experience as positive or negative? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Did you have any learning difficulties in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Are you currently in school or a training program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Who is in your family? (parents, siblings, children, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Who do you live with currently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Where do you currently live? [ ] Your own apartment/home [ ] Someone else’s home [ ] Other
3. Are you currently working? [ ] Full time [ ] Part time [ ] Per Diem [ ] Unemployed
4. How long have you been in this employment situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What do you do for a living? (normal occupation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No NA

1. Has there been any significant person enter or leave your life in the past 90 days? --------- [ ] [ ] [ ]

Good Fair Poor Close Stressful Distant Other

1. How are the relationships in your family? [ ] [ ] [ ] [ ] [ ] [ ] [ ]
2. How are the relationships with your support system? [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**For questions 13-16, please check all that apply** Conflict Abuse Stress Loss Other

1. Are there any problems in your family now? -------------------------------------- [ ] [ ] [ ] [ ] [ ]
2. Were there any problems with your family in the past? ----------------------- [ ] [ ] [ ] [ ] [ ]
3. Are there any problems in your support system now? ------------------------ [ ] [ ] [ ] [ ] [ ]
4. Were there any problems in the past with your support system? ---------- [ ] [ ] [ ] [ ] [ ]
5. What is your marital stat us now? [ ] Single/Never Married [ ] Married [ ] Living as Married [ ] Divorced [ ] Widowed

Yes No NA

1. Have you ever had problems with marriage/relationships? ------------------------------------------ [ ] [ ] [ ]
2. If yes, please briefly describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Yes No NA

1. Do you have close friends? --------------------------------------------------------------------------------- [ ] [ ] [ ]
2. Do you have any problems with friendships? ---------------------------------------------------------- [ ] [ ] [ ]
3. Do you get along well with others (neighbors, co-workers, etc)?------------------------------- [ ] [ ] [ ]
4. What do you like to do for fun and/or relaxation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Military:**  (leave blank if not applicable)

Branch: Army \_\_\_ Navy \_\_\_ Air Force \_\_\_ Marines \_\_\_ Coast Guard \_\_\_ Merchant Marine \_\_\_

Drafted \_\_\_\_\_ Enlisted \_\_\_\_\_\_ Years of Service: From \_\_\_\_\_\_\_ To \_\_\_\_\_\_\_

Type of Discharge:

Still active\_\_\_\_ Honorable \_\_\_\_ General \_\_\_\_ Bad Conduct \_\_\_ Dishonorable \_\_\_

Any Further information you are willing to disclose at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Legal History**

Yes No N/A

1. Have you ever had a DUI? ---------------------------------------------------------------------------------- [ ] [ ] [ ]
2. Have you ever been arrested? IF NO SKIP TO NEXT SECTION--------------------------------- [ ] [ ] [ ]
3. In the past month? ------------------------------------------------------------------------------------------- [ ] [ ] [ ]
4. If yes, for what and how many times ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. In the past year? ---------------------------------------------------------------------------------------------- [ ] [ ] [ ]
2. If yes, for what and how many times ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Yes No NA

1. Have you ever been convicted of a crime (other than traffic tickets) ---------------------------- [ ] [ ] [ ]
2. If yes, for what and when ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Have you ever been incarcerated? ----------------------------------------------------------------------- [ ] [ ] [ ]
2. If yes, how many times, where and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Are you currently on probation or parole? -------------------------------------------------------------- [ ] [ ] [ ]

**Work History**

Yes No NA

1. What is your work history like? [ ] Good/Steady [ ] Poor [ ] Sporadic [ ] Other
2. How long do you normally keep a job? [ ] Weeks [ ] Months [ ] Years
3. Do you have a profession, trade or skill? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Are you retired? ---------------------------------------------------------------------------------------------- [ ] [ ] [ ]
2. What kind of work did you do in the past or are currently doing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Have you ever served in the military? ------------------------------------------------------------------- [ ] [ ] [ ]
2. If yes, are you: [ ] Active [ ] Retired [ ] Other Which branch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income and Basic Needs**

Yes No NA

1. Do you have an income currently?----------------------------------------------------------------------- [ ] [ ] [ ]
2. If yes, Is it enough to meet your basic needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you currently in need of any type of financial assistance? ------------------------------------ [ ] [ ] [ ]
4. If yes, what type of assistance do you need? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are you on Social Security or Disability income? ----------------------------------------------------- [ ] [ ] [ ]
2. If no, have you ever made application and been turned down? ---------------------------------- [ ] [ ] [ ]
3. Do you need assistance with any of the items below?
   1. Shelter/Housing ------------------------------------------------------------------------------------ [ ] [ ] [ ]
   2. Clothing ---------------------------------------------------------------------------------------------- [ ] [ ] [ ]
   3. Medical Care --------------------------------------------------------------------------------------- [ ] [ ] [ ]
   4. Food -------------------------------------------------------------------------------------------------- [ ] [ ] [ ]
   5. Transportation ------------------------------------------------------------------------------------- [ ] [ ] [ ]
   6. Dental/Vision Care -------------------------------------------------------------------------------- [ ] [ ] [ ]
   7. Utilities ----------------------------------------------------------------------------------------------- [ ] [ ] [ ]
   8. Hygiene Products--------------------------------------------------------------------------------- [ ] [ ] [ ]
4. Are you currently homeless? ----------------------------------------------------------------------------- [ ] [ ] [ ]
5. If yes, for how long? [ ] Less than 30 days [ ] 1-6 months [ ] 1-5 years [ ] 5+ years
6. Have you ever been homeless? ----------------------------------------------------------------------- [ ] [ ] [ ]
7. If yes, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. How well do you care for yourself? [ ] Good [ ] Fair [ ] Poor [ ] Other

**Is there anything else that you feel is important to assist you in your treatment?**

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

**Do not fill out below, for clinical use only**

**Behavioral Status Assessment:**

Speech: \_\_\_\_\_\_\_\_\_\_ Interpersonal Behavior: \_\_\_\_\_\_\_\_\_\_\_\_ Motor Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Affect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sensory/Perception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thinking (Process): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thinking (Concept): \_\_\_\_\_\_\_\_\_\_\_\_

Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Judgement: \_\_\_\_\_\_\_\_\_\_\_\_

Summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Clinical Recommendation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Michele Inzelbuch, LCSW, LCADC Date