INITIAL ASSESSMENT

**Use back of pages as needed to complete responses.

IDENTIFYING INFORMATION: Date: _____ Case# _____

Patient _____ Date Of Birth _____ Age _____ Race _____ Sex _____

Marital status: _____Single _____Married _____Living with partner _____Divorced _____Widowed

PRESENTING PROBLEMS: *Describe current problems and what prompted you to seek treatment:*

_____

_____

_____

_____

_____

List name of psychiatrist, if any_____ Length of time under his/her care_____

List current medications prescribed by psychiatrist or other doctor for current problems:

MEDICATION	DOSAGE	FREQUENCY	START DATE	END DATE	PHYSICIAN	SIDE EFFECTS?	BENEFICIAL?

STRESSORS: *Check any stressors below occurring at the time problems & symptoms began or since.*

CLINICAL NOTES

_____ Family Conflict/problems_____

_____ Family move _____

_____ Birth of a child _____

_____ Death of a friend or family _____

_____ Problems at work _____

_____ Marital problems _____

_____ Problems at work (me/spouse) _____

_____ Major Medical Problems _____

_____ Birthday _____

_____ Lost Job _____

_____ Job Change _____

_____ Separation-Month/Yr_____ _____

_____ Divorce-Month/Yr_____ _____

_____ Other _____ _____

_____ Financial Problems _____

_____ Problems with crime or legal system_____

_____ Natural Disaster _____

_____ Relative being abused _____

When did these symptoms and problems begin? _____ What have you done to deal with them until now?_____

Have you had any thoughts of suicide or thoughts of hurting yourself since you began having these difficulties?_____ If yes, *describe these thoughts, plans and when these occur:*

_____

_____

Rate your level of functioning in these areas, by level of impairment, using the scale below.

	CAN'T FUNCTION	SERIOUS	MODERATE	MILD	CLINICIAN NOTES
JOB	( )	( )	( )	( )	_____
MARITAL	( )	( )	( )	( )	_____
FAMILY	( )	( )	( )	( )	_____
FRIENDS	( )	( )	( )	( )	_____
SCHOOL	( )	( )	( )	( )	_____
SPIRITUAL	( )	( )	( )	( )	_____

CHEMICAL HISTORY

ALCOHOL

Age of first use:_____ Last Use: Date/type/amount drank:_____

Alcohol Use Frequency

____None ____Less than 1 x/month ____1-4 x/month ____2-3 x/week ____Daily

Usual Alcohol Consumption

____None ____1-2 drinks/episode ____3-4 drinks/episode ____5 or more/episode

Intoxication Frequency

____Never ____Less than 1x/month ____1-4x/month ____2-3x/week ____Daily

Alcohol-Related Problems: (Check all that apply)

___ Binges ___ Job Problems ___ Sleep problems ___ Physical withdrawal ___ Hangovers
___ DUI's ___ Blackouts ___ Other Arrests ___ Relationship Problems/partner ___Seizures
___Family Problems ___Passing out ___Arguments over my drinking ___Can't stop after 1st drink
___Violent when drinking

SELF-PERCEPTION OF DRINKING: *Describe how you see your drinking:*

___None ___Occasional or Social ___Problem Use ___Psychological Dependence
___Do not want to stop ___Addicted/Cannot stop ___Want to stop

OTHER SUBSTANCE USE: *Check Frequency and Duration for each drug used in the last 12 months*

	FREQUENCY OF USE			*DURATION OF USE*			
	Daily	Weekly Or Less	Monthly	Amount Used/Episode	Less than One Year	More than One Year	Age Began Using
Marijuana	( )	( )	( )	_____	( )	( )	_____
Sedative	( )	( )	( )	_____	( )	( )	_____
Stimulant	( )	( )	( )	_____	( )	( )	_____
Cocaine	( )	( )	( )	_____	( )	( )	_____
Opiates	( )	( )	( )	_____	( )	( )	_____
Inhalants	( )	( )	( )	_____	( )	( )	_____
Hallucinogens	( )	( )	( )	_____	( )	( )	_____
Prescription Drugs	( )	( )	( )	_____	( )	( )	_____

Last Use: Date/Drug(s)/Amount used:_____

___Caffeine: Coffee-# of cups per day ____ ___Tobacco (If cigarettes, # per day_____)
Soft drinks-# of drinks per day ____

Drug-Related Problems: *(Check all that apply)*
___Binges ___Work Problems ___Sleep problems ___Physical withdrawal ___Hangovers
___Arrests ___Relationship Problems ___Family Problems ___Blackouts ___Passing out
___Arguments over my use ___Can't stop using ___Violent when using

SELF-PERCEPTION OF USAGE: *Describe how you see your drug use:*
___None ___Occasional/Social ___Problem Use ___Psychological Dependence
___Don't want to stop ___Addicted/Can't stop ___Want to stop
IMMEDIATE FAMILY:

_____ Never been in serious relationship _____ Not currently in relationship

Years married to current spouse or living with significant other/partner: _____

Spouse/Partner Name: _____Occupation: _____
Spouse/Partner Employer: _____

OTHER MEMBERS OF HOUSEHOLD

NAME	RELATIONSHIP	AGE

LIST CHILDREN-YOURS OR PARTNER'S NOT IN HOME

NAME	BIOLOGICAL/STEP CHILD	AGE

FREQUENCY OF VISITATION WITH ABOVE:_____

List strengths in current relationship:_____
_____
_____

Describe your relationship with your CURRENT partner or spouse: Include level of intimacy, communication, problem-solving and conflict resolution. Identify any problems in this relationship and stressors you may be experiencing in this relationship. (*Use BACK IF NEEDED)*
_____
_____
_____
_____
_____

Describe relationship(s)with your children and partner's children or stepchildren:
_____
_____
_____
_____

What do you and your spouse/partner do together (as a couple alone) to relax or have fun, including sports and other events or activities?_____
_____

Describe any past unresolved or current problems/issues during your adult life with your family (parents/siblings) or in-laws: _____
_____
_____

_____

Describe any cultural influences on your adult life and situation: _____

_____

_____

SPIRITUALITY:

Do you believe in a Higher Power? _____ What/Who is your Higher Power? _____
Religious Affiliation: _____ ( )Practicing ( )Non-Practicing
How do you practice your spiritual life? _____
Are you satisfied with your spiritual life? _____ If not, what would you like to change?

_____

Do you see a need for assistance in the form of spiritual counseling to address concerns about your spiritual life? _____ If yes,do you have someone you can contact for this service? ____
If not, do you want assistance in finding someone who provides spiritual counseling? _____
PREVIOUS PSYCHOLOGICAL AND/OR SUBSTANCE USE PROBLEMS AND TREATMENT:
List previous meds. prescribed by psychiatrist or other doctor for prior emotional problems:

MEDICATION	DOSAGE	FREQUENCY	START DATE	END DATE	PHYSICIAN	SIDE EFFECTS?	BENEFICIAL?

HOSPITALIZATIONS: (For *psychiatric or substance abuse* problems only):

DATES	FACILITY/MD/THERAPIST	PRESENTING PROBLEM	OUTCOME

OUTPATIENT THERAPY: (For *psychiatric or substance abuse* problems only):

DATES	THERAPIST	PRESENTING PROBLEM	OUTCOME

History of involvement in Support/Self Help Groups:_____

Check any other problems you experienced but *WERE NOT TREATED FOR* in the following areas?

_____ Panic Attacks
_____ Phobias
_____ Behavior Problems
_____ Alcohol abuse/dependence (circle)
_____ Drug abuse/dependence (circle)
_____ Impulsive behavior

_____ Depression _____ Aggressive behavior towards persons
_____ Setting fires _____ Destruction of property
_____ Illegal behavior _____ Suicidal thoughts/attempts (circle)
_____ Cruelty to animals_____ Problems with partner(s)

If any apply to you, describe each problem, age when problem(s) occurred, duration of each problem and how each problem was resolved: _____
_____
_____
_____
_____
_____

EMPLOYMENT:

_____Currently Employed	_____Currently Unemployed
Current Employer _____	Last Employer _____
Position _____	Position _____
Yrs. Employed _____	Length of unemployment _____Months _____Years
_____Part-Time _____Full-Time	_____Part-Time _____Full-Time
Average # Hrs. worked per week:_____	Average # Hrs. worked per week _____
Conflicts with co-workers Yes No	Reason for Leaving _____
Conflicts with supervisor Yes No	_____

EDUCATION:

Highest grade level completed: _____ Degree/Major:_____
Currently attending school: YES NO Full-Time _____ Part-Time _____
School Currently Attending _____ Curriculum _____

LEGAL:

Are you involved in any civil litigation? _____ If yes, describe:_____
_____
Do you have any criminal charges pending? _____ If yes, describe:_____
_____
Are you on probation/parole? _____ Length of probation: _____
How much time have you served on your probation:_____
Is your probation unsupervised or supervised? _____
If supervised, identify probation/parole officer: _____
Are you seeking therapy as a condition of probation, parole or a legal diversion program? ____

SOCIAL ACTIVITIES/INTERPERSONAL SKILLS:

What do you do in your leisure time to relax and have fun (hobbies, sports, etc) and how often:
_____

Has there been a change in your level of involvement in these activities? _____ If yes, please explain:_____

Do you spend more time in solitary or social leisure activities? _____

What types of things do you do with friends and how often? _____

Describe yourself socially: Shy Withdrawn Outgoing Follower Leader

How many *close friends* do you have? _____ Who do you go to for support? _____

Do you have difficulty making or keeping friends? _____ If yes, describe difficulties: _____

MEDICAL HISTORY:
Primary Care/Family physician: _____ Date of last physical exam:_____

MEDICAL PROBLEM	MEDICATIONS	TREATING PHYSICIAN

MAJOR SURGERIES	YEAR	MAJOR ILLNESSES	YEAR

Allergies to foods or medications:_____
FAMILY PSYCHIATRIC HISTORY OF EMOTIONAL/MENTAL PROBLEMS-Include attempted & completed suicides:

RELATIONSHIP TO YOU	PROBLEM(S)	TREATED (YES/NO)	CURRENT CONDITION

FAMILY MEDICAL HISTORY-Include cardiovascular disease, kidney disease, diabetes, cancer, etc.:

RELATIONSHIP TO YOU	PROBLEM(S)

FAMILY CHEMICAL HISTORY – DRUG AND ALCOHOL (Name type of drug if known:

RELATIONSHIP TO YOU	PROBLEM(S)	TREATED (YES/NO)	CURRENT CONDITION

CLIENT STRENGTHS: ***Describe your strengths:***_____

_____

CLIENT TREATMENT GOALS:

Reviewing the information you provided in this questionnaire and the SYMPTOM CHECKLIST, list the goals or outcomes you would like to accomplish in therapy for yourself – not others.

_____

_____

_____

_____

_____

_____

_____

_____ _____

CLIENT SIGNATURE **DATE**

_____ _____

CLINICIAN OBTAINING DATA AND COMPLETING EVALUATION **DATE**

Revised 11/5/10