

RIVERVALLEY BEHAVIORAL HEALTH
ADMISSION/PSYCHOSOCIAL ASSESSMENT AND HISTORY

Client Name _____

GRID# _____

Date of Admission: _____

Ethnicity: Caucasian African American Biracial Hispanic Other

Date of Birth: _____ Age: _____ Sex: Male Female

Marital Status: Single Married Divorced Separated Cohabitating

Widow/Widower: _____

Current Living Situation: Home Other _____

Who lives in the household: _____

Referral Source: _____

Relationship: Self Parent DCBS DJJ Other _____

Legal Guardian: _____

Address: _____

Treatment is: Voluntary Court Ordered Inpatient Outpatient
 Other _____

I. CURRENT SYMPTOMS

* Are you feeling: depressed, hopeless, without interest, without energy, without motivation? Would family or friends describe you this way? Yes No

* Have these feelings lasted at least 2 weeks? Yes No

Have they lasted at least 6 months and been present most days, most of the day? Yes No

* Have you been thinking of death or suicide? Yes No

* Have you thought of a plan for committing suicide? Yes No

* Have you acted on that plan? Yes No

What was the result of those actions? _____

* Has your sleep been different from your normal pattern over this same period? Yes No

Describe your current sleeping pattern(s): _____

Describe your typical sleeping pattern(s): _____

* Have you been experiencing any chronic physical problems during this same period? Yes No

Describe these difficulties: _____

Did you experience a traumatic event or negative situation around the time that these feelings first started (e.g. loss of a loved one, divorce, trauma, disabling illness, job loss, significant financial loss, legal difficulties)? Yes No
Describe what has occurred: _____

Are you currently using alcohol or drugs? Has your use of alcohol or drugs changed since you began to experience these symptoms? Yes No

Are you experiencing any of the following (or has anyone observed or described you as): Unusually up mood or manic, needing much less sleep than normal, taking unusual risks, more preoccupied with religion, feeling of invincibility, hypersexual, unusually irresponsible, extremely agitated, unusually disorganized and scattered in your thinking? Yes No

How long have these symptoms or feelings been going on? _____

*** Have you been thinking of death or suicide? Yes No**

*** Have you thought of a plan for committing suicide? Yes No**

*** Have you acted on that plan? Yes No**

What was the result of those actions? _____

*** Has your sleep been different from your normal pattern over this same period? Yes No**

Describe your current sleeping pattern(s): _____

Describe your typical sleeping pattern(s): _____

*** Has there been any significant drug or alcohol use during this time period or during the time immediately preceding this time period? Yes No**

[offer to go to substance abuse cluster questions at this time. If declined, clinician will need to return to this decision at some time during the assessment-tag the substance abuse section as requiring answers/action]

*** Have you made any significant life decisions during this time period (e.g. ended or began a relationship, spent an unusually large amount of money on a major purchase, moved, or began/ended a job/educational experience)? Yes No**

Describe this/these decisions: _____

* Have there been any legal problems during this time period? Yes No
Describe the problem(s): _____

*

Have you ever used drugs, or prescription medication that was not prescribed for you, or used prescribed medication in a manner other than what your physician prescribed? How often do you consume alcohol, and how many drinks do you have in a day? Yes No

* Do any family members have a problem with alcohol or substance use? Yes No

Check all that apply:

- Mother
- Father
- Brother(s)
- Sister(s)
- Spouse
- Maternal grandmother
- Maternal grandfather
- Paternal grandmother
- Paternal grandfather
- Children

Check all use that applies:

* Alcohol

* Beer

Age of first use _____

Age of continuous/regular use _____

Usual amount when using _____

How often used _____

Date of last use _____

Most ever used _____

* Wine

Age of first use _____

Age of continuous/regular use _____

Usual amount when using _____

How often used _____

Date of last use _____

Most ever used _____

* Distilled liquor

Age of first use ____
Age of continuous/regular use ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

- * **Other**

Age of first use ____
Age of continuous/regular use ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

- * **Marijuana**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

- * **Tranquilizers**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

- * **PCP**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

- * **Sedatives**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ * **Amphetamines**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ * **Opiates**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ * **Solvents**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ * **Hallucinogens**

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____

Most ever used ____

- * OTC medications (list)

*
○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*
○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*
○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*
○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*
○ _____

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ * **Prescription medication (list)**

○ _____

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ _____

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ _____

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____
How often used ____
Date of last use ____
Most ever used ____

○ _____

Age of first use ____
Age of continuous/regular use ____
How it's used/route of delivery ____
Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*

○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

○ * Other (list)

*

○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*

○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

*

○ _____

Age of first use ____

Age of continuous/regular use ____

How it's used/route of delivery ____

Usual amount when using ____

How often used ____

Date of last use ____

Most ever used ____

○ *

Age of first use _____
Age of continuous/regular use _____
How it's used/route of delivery _____
Usual amount when using _____
How often used _____
Date of last use _____
Most ever used _____

○ *

Age of first use _____
Age of continuous/regular use _____
How it's used/route of delivery _____
Usual amount when using _____
How often used _____
Date of last use _____
Most ever used _____

When using, have you ever experienced (check all that apply):

- **Blackouts**
- **Passed out**
- **Increased tolerance**
- **Decreased tolerance**
- **Hangovers**

* ○ **Withdrawal symptoms**

Describe them _____

- **Unsuccessful attempts to stop/cut back use**
- **Feelings of guilt/shame/embarrassment about behavior during active use of substance(s)**

What's your longest period of time without using substances? _____

* **Have you ever attended a 12-step group? Yes No**

Check all that apply:

○ * **AA**

How often? _____
Still attending?

○ * **NA**

How often? ____
Still attending?

- * **Other ____**

How often? ____
Still attending?

* **Have you been involved in any substance abuse treatment? Yes No**

Check all that apply:

- * **Inpatient**

When ____
Where ____
Beneficial?
Court ordered?

- * **Residential**

When ____
Where ____
Beneficial?
Court ordered?

- * **Intensive outpatient**

When ____
Where ____
Beneficial?
Court ordered?

- * **Group therapy**

When ____
Where ____
Beneficial?
Court ordered?

- * **Individual outpatient therapy**

When ____
Where ____
Beneficial?
Court ordered?

* Have you engaged in any illegal activity during these experiences or in an attempt to gain access to the substance(s) of abuse? Yes No
Describe them: _____

* Have there been any significant changes to your life as a result of these activities (e.g. loss of finances, loss of a relationship, loss of a job/education, legal problems)? Yes No
Describe them: _____

*

Are you having unusual or bizarre thoughts or feelings, or have friends or family told you that you are acting strange? Yes No

* Have there been experiences of hearing/seeing/smelling/feeling things that no one else around you experiences? Yes No
Describe the nature of these: _____
How often do they occur? _____

* Have these experiences had an effect on your relationships with others? Yes No
What relationships? _____
How were they affected? _____

* Have these experiences occurred exclusively during or around substance use or abuse? Yes No
[If the substance abuse questions have been answered, clinician shouldn't need to revisit them]

* Are there any current legal problems as a result of these experiences? Yes No
Describe these problems: _____

* Have these experiences occurred exclusively during or around a time when there have been significant mood problems? Yes No
[If the mood disorder questions have been answered, clinician shouldn't need to revisit them]

* Have there been significant mood problems in your past that were NOT accompanied by similar experiences as above? Yes No
[If the mood disorder questions have been answered, clinician shouldn't need to revisit them]

*

Are you experiencing things that others say is not really happening? Yes No

* Are there things you believe are happening to you but others either don't believe they are occurring or don't recognize the supporting evidence you believe exists? Yes No
What is occurring? _____

* Are there things you believe are happening around you (that may or may not be having a direct effect on you) but others either don't believe they are occurring or don't recognize the supporting evidence you believe exists? Yes No
What is occurring? _____

* Do you believe you have special talents or abilities but others either don't believe they exist or don't recognize the supporting evidence you believe exists? Yes No
What are these? _____

* Do you see special meaning in things happening around you that others believe are just part of normal everyday occurrences? Yes No
What are these? _____

*

Are you experiencing any of the following: problems paying attention, trouble concentrating, easily distracted, unusually hyper and overactive, compulsive behaviors (e.g. hair pulling, gambling, stealing, sexual activity), impulsive anger or aggressive outbursts, or any other difficulty controlling impulsive or compulsive behaviors? Yes No

* Have you had great difficulty sustaining attention to uninteresting activities, been unusually hyper/impulsive, or both? Yes No

* Were these difficulties evident in childhood? Yes No
At what age? _____

Did these difficulties lead to problems in nearly every area of your life? Yes No

* Have you ever had difficulty controlling your anger or any aggressive impulses? Yes No

* Has this ever resulted in injury to yourself or others, damage to property or legal difficulties? Yes No

* Did you injure someone else? Yes No

Who were they in relationship to you and what were the injuries? _____

* Did you cause damage to property? Yes No

Please explain: _____

* Did the behavior result in legal difficulties? Yes No

Please explain: _____

* Have you had a significant difficulty relating to anyone in authority (e.g. parent, guardian, boss, police) and any attempts by you to control this behavior usually fails? Yes No

* Did these difficulties begin in childhood in relation to your parent(s), guardian(s), or teacher(s)? Yes No

* Did they lead to significant consequences (legal or otherwise)? Yes No

Please explain: _____

* Have you intentionally either caused harm to others or animals, or have you intentionally stolen or damaged property that has significant value? Yes No

* Were they injuries to others or animals? Yes No

Who were the victims and what was the extent of the injury?

* Was it stolen or damaged property? Yes No

What was the property and was it stolen or damaged? _____

What were the consequences of this behavior (legal or otherwise)?

* Have you had sporadic (yet numerous) difficulties with substance abuse? Yes No

[If not already walked through substance abuse cluster questions, offer them at this point]

* Have you had either short and numerous relationships or had difficulty maintaining most relationships? Yes No

* Have a significant number of these relationships been sexual? Yes No

Describe them and how they ended: _____

* Have any of these relationships involved violence, injury or abuse? Yes No

Describe the violence, injury or abuse: _____

* Have you had difficulty with compulsive behaviors that it seems you can not stop doing even though you may have attempted to stop in the past? Yes No

* Has it involved games of chance? Yes No

What do you gamble on?

- Horses
- Casinos

- Cards**
- Lottery**
- Personal wagers**
- Sporting event**
- Office/work pools**
- Bingo**

Have you ever tried to change the amount you gamble? Yes No

Do you get angry when someone questions or criticizes your gambling? Yes No

Have you ever felt guilty because of your gambling? Yes No

* **Have you ever had significant life problems as a result of your gambling?** Yes No

Check all that apply:

- Legal**
- Family**
- Work**
- School**

Do you ever sell things or borrow money to use for gambling? Yes No

* **Have you ever been to treatment for gambling addiction?** Yes No

Check all that apply:

- * **Inpatient**

When?

Where?

- * **Residential**

When?

Where?

- * **Intensive outpatient**

When?

Where?

- * **Group**

When?

Where?

* **Do you attend Gamblers Anonymous? Yes No**
How often _____

* **Do you utilize the Gambler's Help Line? Yes No**
How often _____

* **Has it involved pulling hair or picking at scabs/sores on your body? Yes No**

* **Has it caused significant hair loss? Yes No**

Where on your body is the hair loss? _____

If you pick at sores/scabs on your body, where are these areas that are affected? _____

* **Has it involved sexual behavior? Yes No**

* **Has it directly caused any illness or STD? Yes No**

Please explain: _____

* **Approximately how many sexual partners have you had? Yes No**

Have you had any inappropriate sexual partners (e.g. parent, guardian, authority figure, sibling, or same-sex relationship even though you don't consider yourself homosexual in orientation)? Yes No

Please list and describe the relationship(s): _____

* **Has it involved fire setting? Yes No**

* **Was this fire setting done almost exclusively for financial or personal gain? Yes No**

Did it result in significant damage to property or was any person or animal injured? Yes No

Please explain: _____

* **Have these behaviors occurred almost exclusively in the presence of substance abuse? Yes No**

[Offer to take clinician to substance abuse cluster questions or return to same at a later time-also require answers to the substance abuse section]

* **Are these behaviors often preceded by intense feeling of need or anxiety, and once completed, followed by feelings of intense relief or satisfaction? Yes No**

Please explain: _____

* Have you made numerous attempts to control or stop these behaviors without any long term effect? Yes No

* Has this involved any formal treatment or the help of others? Yes No
Please explain: _____

* Have you continued these behaviors in spite of experiencing numerous significant consequences as a result (e.g. financial, legal, relational, disease/injury)? Yes No
Please list and describe the consequences experienced: _____

* Have you recently experienced any of the following: Severe anxiety, repeated ER visits for somatic complaints without them finding any source, re-experiencing past traumatic experiences, social avoidance, significantly heightened awareness/startle/vigilance, obsessive thoughts, compulsive behaviors, severe fear of specific things, or avoidance of experiences you fear will lead to anxiety or negative outcomes? Yes No

* Have you had discrete episodes of panic, where you feel consumed by some feeling of impending doom or negative outcome (with or without associated physical symptoms)? Yes No

* Have these episodes led to your avoidance of things/experiences you fear will lead to additional episodes? Yes No

* Have they led to you being nearly completely housebound? Yes No
Please describe your daily routine: _____

What has been the frequency of these episodes (per day, week or month)? _____

Please describe the character of these episodes: _____

* Have you had any physical symptoms associated with these episodes? Yes No
Please list and describe them: _____

* Do you feel a nearly uncontrollable level of background stress or anxiety most days and most of each day? Yes No
Has this experience had a negative effect(s) on any of the following:

* Employment, education, or relationship(s)? Yes No
Please list and describe them: _____

* Have you ever had what you would consider an extremely traumatizing experience (or experiences)? Yes No
Please list and describe them: _____

- * Do you ever re-experience any component of these remembered events (in dreams or otherwise)? Yes No
 Please list and describe them including how intense you feel they are: _____
- * Have you avoided anyone or anything you fear may lead to or intensify a re-experience of these traumatic events? Yes No
 Please list and describe your rationale for avoiding: _____
- * Do you have any physical effects (whether or not they've been medically confirmed/documentated) as a result of the traumatic event? Yes No
 Please list and describe them: _____
- * Do you feel you have a heightened level of anticipation or startle reaction associated with needing to avoid any chance of having a repeat of the traumatic event(s)? Yes No
 Please describe how this feels and what you experience: _____
- * Do you experience intrusive, obsessive thoughts (realistic in nature or not) that you can't seem to stop thinking about in spite of repeated attempts to make them go away? Yes No
 Please describe them and give an approximation of how much of each day is occupied by thinking about them: _____
 What have you done or thought about doing in an attempt to stop having these obsessive thoughts? _____
- * Have these feelings been nearly exclusively the result of or associated with some type of substance use or abuse? Yes No
 [If not already completed, offer to take the clinician to the substance abuse cluster questions]
- * Do you perform repeated actions of any type in a compulsive manner (i.e. the action must be repeated in order to give you some reassurance or peace that either something positive will happen or something negative will not happen)? Yes No
- * Do you consider these actions needed and rational? Yes No
 Please describe them, how often they occur and how much of your day is occupied by them: _____
- * Do others generally consider these actions needed and rational? Yes No
 If not, what kind of feedback do you generally get when these actions are either described by you to others or witnessed by others? _____
- * Have these actions had (as considered by you or anyone else) a negative effect on you or your life? Yes No

Please list and describe: _____

* Have these feelings been nearly exclusively the result of or associated with some type of substance use or abuse? Yes No
[If not already completed, offer to take the clinician to the substance abuse cluster questions]

* Are there social or performance situations which (when experienced) lead to a significant level of anxiety/stress (with or without physical symptoms)? Yes No

* Are these limited to performances of any type (e.g. playing an instrument solo, singing on a stage, giving a speech, giving a sermon, giving a job presentation)? Yes No
Please list and describe: _____

* Does this occur in social situations? Yes No

* Is it limited to situations which are new to you? Yes No
Please list and describe: _____

* Does it occur in nearly all social experiences? Yes No
Please list and describe: _____

* Has it led to your avoidance of subsequent social opportunities or isolation from others? Yes No
Please list and describe: _____

What other negative effects (if any) have these feelings/experiences had on you or your life? _____

* Have these feelings been nearly exclusively the result of or associated with some type of substance use or abuse? Yes No
[If not already completed, offer to take the clinician to the substance abuse cluster questions]

* Are there items (animate or inanimate) or experiences which, when experienced lead to intense anxiety for you and are always (or nearly always) avoided by you when possible? Yes No

Please list them and describe your reactions/feelings towards them:

II. HISTORY OF PREVIOUS MENTAL HEALTH TREATMENT

*

Have you ever experienced mental health problems? Any previous mental health services? Yes No

- * Have you ever attempted suicide? Yes No
 What did the attempt(s) involve? _____
- * Were others aware of your attempt(s)? Yes No
 What was their reaction? _____
- * Were you hospitalized as a result of the attempt(s)? Yes No
 Where? _____
 For how long? _____
- * Have you ever been in treatment before? Yes No
- * Inpatient (list)
 - * When? _____
 Where? _____
 For how long? _____
 - * When? _____
 Where? _____
 For how long? _____
 - * When? _____
 Where? _____
 For how long? _____
 - * When? _____
 Where? _____
 For how long? _____
 - * When? _____
 Where? _____
 For how long? _____
 - * Outpatient (list)
 - * When? _____
 Where? _____
 For how long? _____
 - * When? _____
 Where? _____
 For how long? _____
 - * When? _____

Where? _____
For how long? _____

○ * When? _____
Where? _____
For how long? _____

○ * When? _____
Where? _____
For how long? _____

* Did you take any medications for your difficulties during any of these treatments
(list)? Yes No

○ * _____
What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

○ * _____
What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

○ * _____
What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

○ * _____
What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

- _____
- *
- What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

- *
- What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

- *
- What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

- *
- What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

- *
- What was your dose? _____
How often taken each day? _____
How long were you on it uninterrupted? _____
Was it at all effective? not effective _____
somewhat effective _____
moderately effective very effective _____

- *
- _____

What was your dose? _____
 How often taken each day? _____
 How long were you on it uninterrupted? _____
 Was it at all effective? _____ *not effective*
somewhat effective
moderately effective *very effective*

* Is anyone in your family supportive of you seeking treatment? Yes No

Check all that apply:

- Parents
- Spouse
- Siblings
- Grandparents
- Children
- Other(s) (list) _____

Who do you want involved in your treatment? _____

III. CHILDHOOD DEVELOPMENT

* Is this patient a child or adolescent under the age of 18? Yes No

* Were there any problems with delivery? Yes No

List all that apply:

- Difficult delivery
- Drug exposure during pregnancy
- Eclampsia/pre-eclampsia
- Emergency C-section
- Premature birth

* Low birth weight

Weight? _____

- Infection (baby and/or mother)

* Did you take medications during pregnancy (list) Yes No

* _____
Dose _____

* _____
Dose _____

* _____
Dose _____

* _____

Dose _____

*
○ _____

Dose _____

* Were there any problems in infancy? Yes No

Check all that apply:

- Frequent infections
- Head injury
- Failure to thrive

* Were there any problems with development? Yes No

Check all that apply:

- Poor language skills
- Hearing deficit
- Slow motor development
- Coordination difficulties
- Eye problems
- Head injury
- Broken bones
- Speech problems

List the age at which the following occurred (list in years or months, or use N/A if not known):

Sitting up _____

Crawling _____

Standing alone _____

Walking alone _____

Fed self _____

Dress self _____

First word _____

First sentence _____

Toilet trained _____

Rode tricycle _____

Rode bicycle _____

Tied shoes _____

IV. HISTORY OF PREVIOUS MEDICAL TREATMENT:

* Is there a past history of major medical problems (list)? Yes No

○ *
○ _____

Age of onset _____

○ *
○ _____

Age of onset _____

- * _____ **Age of onset** _____
- * _____ **Age of onset** _____
- * _____ **Age of onset** _____

* Is there a past history of major surgeries (list)? Yes No

- * _____ **Age at the time** _____

* Are there any current medical problems (list)? Yes No

- * _____ **Under control?** Yes No
Stable?
- * _____ **Under control?** Yes No

* Are you on any current medications (list)? Yes No

Dose _____

V. FAMILY HOUSEHOLD INFORMATION

* Are you a child or do you have a legal guardian? Yes No

You currently live with (Check all that apply):

- Biological mother
- Biological father
- Both biological parents
- Step-mother
- Step-father
- Biological parent plus a step-parent
- Adoptive parent(s)

- Grandparent(s)
- Other extended family member(s)
- Other (list) _____

Who has legal custody of this juvenile? _____

* Have parental rights been terminated for either biological parent? Yes No
 Who and why? _____

Type of discipline used in household (Check all that apply):

- Time out
- Grounding
- Taking privileges
- Spanking
- Ignoring
- Positive reinforcement
- Other _____

* Has this child/adolescent ever been placed outside the home (list)? Yes No

- * When? _____
With whom? _____
For how long? _____
- * When? _____
With whom? _____
For how long? _____
- * When? _____
With whom? _____
For how long? _____
- * When? _____
With whom? _____
For how long? _____
- * When? _____
With whom? _____
For how long? _____

* Are the parents in this household employed? Yes No
 Occupation(s) _____

Biological parents are (Check one best answer):

- Married and together

- Married and separated**
- Unmarried and together**
- Never married and separated**
- Divorced and living apart**
- Deceased**
- Unknown**

* Do you have any siblings (list)? Yes No

○ *

Age _____

How related (choose one)?

- Full**
- Half**
- Step**

Living in same home as you? Yes No

○ *

Age _____

How related (choose one)?

- Full**
- Half**
- Step**

Living in same home as you? Yes No

○ *

Age _____

How related (choose one)?

- Full**
- Half**
- Step**

Living in same home as you? Yes No

○ *

Age _____

How related (choose one)?

- Full**
- Half**
- Step**

Living in same home as you? Yes No

○ *

Age _____

How related (choose one)?

- Full**
- Half**
- Step**

Living in same home as you? Yes No

○ *

Age _____
How related (choose one)?

- Full
- Half
- Step

Living in same home as you? Yes No

○ *

Age _____
How related (choose one)?

- Full
- Half
- Step

Living in same home as you? Yes No

○ *

Age _____
How related (choose one)?

- Full
- Half
- Step

Living in same home as you? Yes No

○ *

Age _____
How related (choose one)?

- Full
- Half
- Step

Living in same home as you? Yes No

*

Have your symptoms/difficulties affected others in the family/household? Yes No

In what way? _____

Do you have contact with your biological (Check all that apply):

○ * Mother?

Relationship is:

- Good
- Poor
- Stressful
- Detached

○ * Father?

Relationship is:

- Good

- Poor**
 - Stressful**
 - Detached**
 - *** Siblings?**
 - *****
 - _____
 - Relationship is (choose one):**
 - Good**
 - Poor**
 - Stressful**
 - Detached**
 - *****
 - _____
 - Relationship is (choose one):**
 - Good**
 - Poor**
 - Stressful**
 - Detached**
 - *****
 - _____
 - Relationship is (choose one):**
 - Good**
 - Poor**
 - Stressful**
 - Detached**
 - *****
 - _____
 - Relationship is (choose one):**
 - Good**
 - Poor**
 - Stressful**
 - Detached**
 - *****
 - _____
 - Relationship is (choose one):**
 - Good**
 - Poor**
 - Stressful**
 - Detached**
 - *****
 - _____
 - Relationship is (choose one):**
 - Good**
 - Poor**
 - Stressful**
 - Detached**

○ ***** _____

Relationship is (choose one):

- Good**
- Poor**
- Stressful**
- Detached**

○ ***** _____

Relationship is (choose one):

- Good**
- Poor**
- Stressful**
- Detached**

***** Are there people who live in your home (or are there a substantial amount of time) who aren't your parents, guardians, spouse, or siblings (list)? Yes No

○ ***** _____

If related, how? _____

***** Are there any financial issues/stressors in the home? Yes No

Choose one:

- Minimal**
- Moderate**
- Severe**

What kind of discipline was used and how were conflicts resolved in your family of origin (choose all that apply)?

- Negotiation**
- Take turns**
- Time out**
- Grounding**
- Corporal punishment**
- Ignoring**

- Manipulation
- Coercion
- Threats
- Physical fights

VI. MARITAL/DIVORCE HISTORY:

* Have you ever been married (list, begin with most recent)? Yes No

Year married ____

Year ended (leave blank if still married) * ____

- Divorce
- Death
- Other

Year married ____

Year ended (leave blank if still married) * ____

- Divorce
- Death
- Other

Year married ____

Year ended (leave blank if still married) * ____

- Divorce
- Death
- Other

Year married ____

Year ended (leave blank if still married) * ____

- Divorce
- Death
- Other

Year married ____

Year ended (leave blank if still married) * ____

- Divorce
- Death
- Other

VII. CHILDREN/AGES:

* Have you ever had children (list their names)? Yes No

_____ *

Age _____
Lives (choose one):

- With me**
- With other parent**
- As an adult still in parent's home**
- As an independent adult**
- Other**

○ ***** _____

Age _____

Lives (choose one):

- With me**
- With other parent**
- As an adult still in parent's home**
- As an independent adult**
- Other**

○ ***** _____

Age _____

Lives (choose one):

- With me**
- With other parent**
- As an adult still in parent's home**
- As an independent adult**
- Other**

○ ***** _____

Age _____

Lives (choose one):

- With me**
- With other parent**
- As an adult still in parent's home**
- As an independent adult**
- Other**

○ ***** _____

Age _____

Lives (choose one):

- With me**
- With other parent**
- As an adult still in parent's home**
- As an independent adult**
- Other**

○ ***** _____

Age _____

Lives (choose one):

- With me**
- With other parent**
- As an adult still in parent's home**
- As an independent adult**

- Other**
- ***** _____
Age _____
Lives (choose one):
 - With me**
 - With other parent**
 - As an adult still in parent's home**
 - As an independent adult**
 - Other**
- ***** _____
Age _____
Lives (choose one):
 - With me**
 - With other parent**
 - As an adult still in parent's home**
 - As an independent adult**
 - Other**
- ***** _____
Age _____
Lives (choose one):
 - With me**
 - With other parent**
 - As an adult still in parent's home**
 - As an independent adult**
 - Other**
- ***** _____
Age _____
Lives (choose one):
 - With me**
 - With other parent**
 - As an adult still in parent's home**
 - As an independent adult**
 - Other**

How does everyone get along in your home (choose one best answer)?

- Poor**
- Fair**
- Good**
- Variable**
- Detached**
- Other** _____

What types of discipline/conflict resolution have been used in your home (choose all that apply)?

- Negotiation**

- Take turns**
- Time out**
- Grounding**
- Corporal punishment**
- Ignoring**
- Manipulation**
- Coercion**
- Threats**
- Physical fights**

VIII. CULTURAL HISTORY:

What do you consider the culture of your family of origin (describe)? _____

What do you consider the culture of your current family/living setting (describe)? _____

* Are there particular cultural aspects of your current life or in your past history we should be aware of and sensitive to? Yes No

Please list and describe: _____

IX. FAMILY HISTORY OF PHYSICAL/PSYCHIATRIC ILLNESS:

* Does anyone in your biological family (alive or deceased) have/had a significant physical illness? Yes No

- * Grandparent(s)
Describe _____
- * Parent(s)
Describe _____
- * Aunts/uncles
Describe _____
- * Sibling(s)
Describe _____
- * Other _____
Describe _____

* Does anyone in your biological family (alive or deceased) have/had a significant mental illness? Yes No

- * Grandparent(s)
Describe _____

- *** Parent(s)**
Describe _____
- *** Aunts/uncles**
Describe _____
- *** Sibling(s)**
Describe _____
- *** Other** _____
Describe _____

X. PHYSICAL/EMOTIONAL/SEXUAL ABUSE HISTORY:

***** Have you ever been the victim of any kind of abuse? Yes No

***** Have you ever been physically abused? Yes No
 Age at time abuse occurred _____
 How long did the abuse last? _____
 Who abused you? _____

***** Have you ever been emotionally abused? Yes No
 Age at time abuse occurred _____
 How long did the abuse last? _____
 Who abused you? _____

***** Have you ever been sexually abused? Yes No
 Age at time abuse occurred _____
 How long did the abuse last? _____
 Who abused you? _____

***** Were you ever significantly neglected as a child/adolescent? Yes No
 Age at time abuse occurred _____
 How long did the abuse last? _____
 Who abused you? _____

***** Are you currently in an abusive relationship? Yes No
 Describe the abuse _____
 How long have you been in this relationship? _____

***** Have you ever abused anyone? Yes No

- * Was it physical abuse? Yes No
 [qwt 'ci g'cpf 'ci g'qhxlevlo 'cvvlo g'cdwug'qeewttgf ____
 How long did the abuse last? ____
 Who did you abuse? ____
- * Was it emotional abuse? Yes No
 [qwt 'ci g'cpf 'ci g'qhxlevlo 'cvvlo g'cdwug'qeewttgf ____
 How long did the abuse last? ____
 Who did you abuse? ____
- * Was it sexual abuse? Yes No
 [qwt 'ci g'cpf 'ci g'qhxlevlo 'cvvlo g'cdwug'qeewttgf ____
 How long did the abuse last? ____
 Who did you abuse? ____
- * Was it neglect of a child/adolescent? Yes No
 [qwt 'ci g'cpf 'ci g'qhxlevlo 'cvvlo g'cdwug'qeewttgf ____
 How long did the abuse last? ____
 Who did you abuse? ____

XI. EDUCATION:

Current grade (or highest grade completed): _____
 Name of school _____

*

What year did you graduate high school or obtain your GED? _____
 If you should be attending school now but are not, please explain why not: _____

- * Were you ever in gifted classes? Yes No
 What grade? _____
- * Did you ever have to repeat a grade? Yes No
 What grade(s)? _____
- * Do you have any learning disabilities? Yes No
 Check all that apply:
 Math
 Reading
 Spelling
 Speech
 Writing
 Other _____

- * Were you ever in special education classes? Yes No
 What grade(s)? _____
- * Were you ever in classes for emotionally or behaviorally disabled children? Yes No
 What grade(s)? _____
 What was the nature of your difficulty? _____
- * Have you ever been suspended (choose all that apply)? Yes No
 In school
 Out of school
 How many times (choose one)?
 Once
 A few times
 Quite a bit
- * Have you ever been expelled? Yes No
 What was the reason? _____
 What Grade(s) _____
- * Have the difficulties you experience ever affected your performance or relationships at school? Yes No
 Please describe how they were affected: _____
- * Have you had any education beyond High School (even if you didn't complete your high school education)? Yes No
 Was it a professional, technical or trade school? Yes No
 What was the name of the school/program? _____
- * Are you still attending? Yes No
 When will you finish? _____
- * Did you complete the program? Yes No
 What trade/skill did you learn? _____
 If not completed and not attending please explain: _____
- * Was it a college or university? Yes No
 What was the name of the college or university? _____
- * Are you still attending? Yes No
 When will you finish? _____
- * Did you complete a program or degree? Yes No
 What certificate or degree did you earn? _____
 If not completed and not attending please explain: _____

- * Was it a professional or trade internship or on-the-job training? Yes No
 What company or individual were you training with? _____
- * Are you still in training? Yes No
 When will you finish? _____
- * Did you complete the training? Yes No
 What skill, certificate or professional qualification did you learn/earn? _____
- * If not completed and not attending please explain: _____
- * Have you had any post-graduate schooling or training (e.g. Masters, PhD, MD, DO, Lawyer, MBA, EdD)? Yes No
 What was the name of the school, program, college or university?

- * Are you still attending? Yes No
 When will you finish? _____
- * Did you complete the program? Yes No
 What skill, certificate or professional qualification did you learn/earn? _____
 If not completed and not attending please explain: _____

XII. SOCIAL HABITS:

Do you prefer to be with friends or alone (pick one):

- Friends
- Alone
- Doesn't matter, like both

* Do you make friends easily? Yes No

What difficulties do you have making friends? _____

* Are most of your friends the same age (+/- one year if child, two years if adolescent, 5 years if an adult)? Yes No

What is it about older/younger friends that you prefer? _____

In general, what is the quality of your interactions with (other) adults (other than immediate family)(choose one best answer)?

- Non-existent
- Poor
- Fair
- Good
- Excellent

What type(s) of activities/hobbies/interests outside of work/school do you enjoy? _____

What are your favorite hobbies or interests? _____

How many close/intimate friends do you have? _____

Are you fairly comfortable in social situations/interactions? Yes No

Who do you talk to when you need help (choose all that apply)?

- Family
- Friends
- Best friend
- Significant other
- Religious leader
- Counselor/therapist
- Other professional
- Other _____

XIII. EMPLOYMENT

*** Are you currently or have you ever been employed or worked as an independent contractor earning a wage or any type of compensation? Yes No**

*** Are you currently employed? Yes No**

Name of employer: _____

Years at current employer: _____

Type of work _____

*** Have you ever been fired from a job? Yes No**

How many times? _____

What were the reasons? _____

What other type of work have you done in the past? _____

*** Are you currently or have you ever been on disability? Yes No**

For how long? _____

For what reasons? _____

XIV. MILITARY HISTORY:

*** Are you currently in or ever been in a branch of military service (active or reserves)?**

Branch (choose all that apply): Yes No

- Army
- Navy
- Air Force
- Marines
- Coast Guard
- Other _____

How many years did/have you served? _____

If discharged, what was the nature of your discharge? _____

XV. STRENGTHS AND WEAKNESSES (as stated by client):

Strengths:

Weaknesses:

XVI. LEGAL INVOLVEMENT:

* Have you ever been arrested or charged with a crime? Yes No

How old were you? _____

What was the charge? _____

* Were you incarcerated? Yes No

For how long? _____

Where? _____

* Are you currently and/or ever been on probation/parole? Yes No

Name of probation/parole officer: _____

Describe any other police involvement: _____

XVII. SPIRITUAL/RELIGIOUS INFLUENCE:

* Do you have a religious affiliation or do you identify with any form of spiritual belief? Yes No

Please describe your religion/spiritual belief: _____

* Do you currently attend a place of worship? Yes No

Choose one best answer:

- Several times a week
- Weekly
- A couple of times a month
- A few times a year
- rarely

Is your place of worship a significant part of your support system? Yes No

When you have any struggles/difficulties, do you generally believe things will eventually get better? Yes No

Are you able to accept help from others when it is offered? Yes No

Do you feel there is purpose to your life? Yes No

XVIII. SEXUAL HISTORY

* Have you ever been sexually active? Yes No

Are you currently sexually active? Yes No

Do you have a history of sexually transmitted diseases? Yes No

Are you aware of the "high risk" diseases associated with drinking and using drugs such as HIV, STD, and TB? Yes No

How many sexual partners have you had in the past six months? _____

XIX. MENTAL STATUS EXAM:

Appearance/grooming (choose all that apply):

- Neat
- Unkempt
- Good hygiene

- Fair hygiene**
- Bad hygiene**
- Appropriate dress**
- Unusual/inappropriate dress**
- Recent significant weight gain**
- Recent significant weight loss**
- Other _____**

Interaction quality (choose all that apply):

- Friendly**
- Cooperative**
- Hostile**
- Belligerent**
- Guarded**
- Evasive**
- Flippant**
- Detached**
- Passive**
- Other _____**

Attention/concentration (choose all that apply):

- Alert**
- Attentive**
- Focused**
- Bored**
- Confused**
- Listless**
- Distractible**
- Needed redirection**
- Other _____**

Psychomotor activity (choose all that apply):

- Normal**
- Overactive**
- Slowed**
- Fidgety**
- Facial tics/twitches**
- Other _____**

Observed affect (choose all that apply):

- Full range**
- Flat**
- Appropriate**
- Labile**
- Blunted**
- Constricted**
- Intense/reactive**
- Incongruent**
- Other _____**

Report of mood (choose all that apply):

- Euthymic**
- Depressed**
- Anxious**
- Irritable**
- Angry**

- Euphoric**

- Other** _____

Perceptions/thought content (choose all that apply):

- Hallucinations**

- Delusions**

- Circumstantiality**

- Tangentiality**

- Paucity**

- Illogical**

- Grandiose**

- Suspicious**

- Other** _____

Speech (choose all that apply):

- Clear**

- Coherent**

- Relevant**

- Loud**

- Verbose**

- Soft**

- Incoherent**

- Pressured**

- Impoverished**

- Word salad**

- Neologisms**

- Unusual content**

- Other** _____

Reliability (choose all that apply):

- Reliable/honest**

- Unable to establish**

- Questionable**

- Unreliable**

- Other** _____

Orientation (choose all that apply):

- Person**

- Place**

- Time**

- Date**

- Season**

Memory (choose all that apply):

- Immediate intact**

- Recent intact**

- Remote intact**

- Deficit of immediate recall**

- Deficit of recent recall**

- Deficit of remote recall**

- Other** _____

- Mode of testing used by interviewer:** _____

Intelligence (choose all that apply):

- Below average**

- Average**

- Above average**

- Unable to determine**
 - Other _____**
- Insight (choose all that apply):**
- Understands nature of problem**
 - In denial**
 - Blames others**
 - Unaware of difficulty**
 - Other _____**
- Judgment (choose all that apply):**
- Appreciates consequences of behavior**
 - Marginal**
 - Doesn't understand consequences**
 - Poor**
 - Intact**
 - Other _____**

XX. CLINICAL IMPRESSION:

(DSM-IV diagnosis) Note any diagnosis to be ruled out (do not describe, use numeric code)

- AXIS I:** _____

- AXIS II:** _____
- AXIS II:** _____
- AXIS II:** _____

- AXIS III:** _____
- AXIS III:** _____
- AXIS III:** _____
- AXIS III:** _____
- AXIS III:** _____

AXIS IV:

- * Problem with primary support group**
Specify _____
- * Problem related to social environment**
Specify _____
- * Educational problem**
Specify _____

- * **Occupational problem**
Specify _____
- * **Housing problem:**
Specify _____
- * **Economic problem**
Specify _____
- * **Problem with access to health care:**
Specify _____
- * **Problem related to interaction with legal system**
Specify _____
- * **Other psychosocial and environmental problem**
Specify _____

AXIS V: Initial GAF _____ Highest GAF past year _____ Current GAF _____

XXI. RECENT STRESSFUL LIFE SITUATIONS:

Please check any of the following that have occurred in the last two (2) years:

- Recently married**
- Recently divorce**
- Legal issues**
- Engagement**
- Separation**
- Break-up of important relationship**
- Child left home**
- Serious argument**
- Personal injury/illness**
- Bad health**
- Death of a loved one**
- Retired/lost job**
- Negative behavior of family member**
- Significant changes at work/school**
- Moved**
- In too much debt**
- Sexual issues**
- Physical/sexual/emotional abuse**
- Homelessness**
- Birth of child**
- Hospitalizations**
- Other _____**

XXII. PATIENT STRENGTHS (identified by clinician):

Patient Strengths (check all that apply):

- Average/above functioning**
- Has transportation**
- Family/other support**
- Good physical health**
- Maintains employment/school responsibilities**
- Good self care**
- Good insight re: problems**
- Good self esteem**
- Good verbal skills**
- Cooperative/motivated**
- Other:** _____

Barriers to treatment (check all that apply):

- None**
- Family**
- Work/school interference**
- Spouse interference**
- Transportation problems**
- Health problems**
- Financial problems**
- Below average functioning**
- Limited insight**
- Poor judgment**
- Low self esteem**
- Low frustration tolerance**
- Other:** _____

XXIII. TREATMENT MODALITY/ISSUES (choose all that will be recommended):

- Individual**
- Family**
- Group**
- Marital**
- Collateral**
- Medication**
- Other**

XXIV. DISCHARGE:

CRITERIA FOR DISCHARGE (choose one best answer):

- Achievement of patient's stated goals**
- Treatment termination by mutual agreement between patient and clinician**
- Other:** _____

DISCHARGE PLANS (choose one best answer):

- Transfer to inpatient**
- Transfer to outpatient**
- Transfer to residential**
- Discharge to current home setting**
- Discharge to different home setting**
- Other:** _____

Clinician:	_____ Signature	Title	Date
Psychiatrist:	_____ Signature	Title	Date
Supervisor:	_____ Signature (if required)	Title	Date

INTREPRETIVE SUMMARY/FORMULATION (Treatment teams' comprehensive, holistic view of the client and what problems/needs to address in treatment based on all psychiatric, medical, and psychosocial and psychological assessments.)

What problems/needs will not be addressed in treatment: _____

Clinician:	<hr/> Signature	<hr/>	Title	<hr/> Date
Psychiatrist:	<hr/> Signature	<hr/>	Title	<hr/> Date
Supervisor:	<hr/> Signature (if required)	<hr/>	Title	<hr/> Date