

<u>concern</u>? Y or N If yes, please provide hospital information on next page.

Date: _____ DOB____

Name: ____

INITIAL ASSESSMENT/CONSULTATION

HOSPITAL	<u>YEAR</u>	REASON

EDUCATION_____

- 8. Do you have a High School Diploma or GED? Y or N
- 9. Do you have a college degree? Y or N If yes, major/degree _____

 High School ______
 Years _____

College _____ Years _____

Vocational/Trade School

EMPLOYMENT

- 10. Are you currently employed? Y or N FULL TIME PART TIME TEMP/SEASONAL
- 11. Name of Employer: _____
- 12. Job Title: _____

13. Do you have a profession, trade, or skill? Y or N If yes, specify: _____

ADOLESCENT/MINORS (17yrs & under)

- 14. Grade: _____ School: _____
- 15. How are you performing in school?
- 16. Have you ever experienced bullying or being bullied?
- 17. Do you feel you have a positive or good support by family, friends, loved ones? Y or N
- 18. How many close friends you have?
- 19. Do you enjoy daily activities such as hanging out with friends, family, doing your favorite hobby, etc.? Y or N





Date: _____ DOB

INITIAL ASSESSMENT/CONSULTATION

20. Please circle any of the following that you may have past or present issues with:

Depression Anxiety Sadness Anger Lack of Support Abuse Thoughts of hurting self Thoughts of hurting others Physical Fighting Violence Law Enforcement Moodiness Eating Disorder Attempted Suicide Drugs Trauma Grief Transitional/Adjustment Self-Esteem Sexuality Other: _____

LIFE & FAMILY HISTORY

- 21. Gender: ______ or Ask Me
- 22. Marital Status: _____Single ____Married ____Divorced ____Dating/Relationship ____Separated
- 23. Who lives with you? _____

24. Do you have any children? Y or N If yes, gender & ages: _____

- 25. Who do you have the closest relationship with in your life? _____
- 26. Who do you have the most difficult relationship with?

27. Do you have an active positive social life? Y or N

- 28. Are you able to maintain healthy relationships? Y or N
- 29. Any history of: Emotional Abuse Y or N, Verbal Abuse Y or N, Physical Abuse Y or N Sexual Abuse Y or N, Discriminatory/Neglect Abuse Y or N

30. Any general comment or statement about your family and/or life?

MEDICAL HISTORY

- 31. Any general medical conditions, diagnoses or allergies? Y or N If yes, please explain:
- 32. Any medical condition(s) related to substance use/abuse? Y or N
- 33. Any physical, mental, or learning disabilities? Y or N
- 34. Primary Doctor:

INITIAL ASSESSMENT/CONSULTATION

35. Are you taking any prescribed medications? Y or N If yes, please specify medication, dosage, prescribed for, and prescribing doctor below.

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MEDICATION	DOSAGE	FOR	DOCTOR

- 37. Describe your appetite (eating habits)

 38. Describe your sleeping ______ Average hours of sleep a night______
- 39. Are you sexually active? Y or N If yes, do you use protection/contraceptives _____

SUBSTANCE USE HISTORY

40. Please indicate if you use/do any of the following: ____Cigarettes ____Vape ___Other If yes, how many daily _____

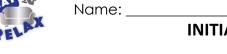
41. Please indicate substance use history below (if applicable):

SUBSTANCE	AGE 1st use	Amount	Frequency	Last Use	Route
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Ecstasy					
Hallucinogens					
Heroin					
Inhalants					
K2/Spice					
Ketamine					
Methamphetamine					
Methadone					
Other Opiates					



Date: _____ DOB

INITIAL ASSESSMENT/CONSULTATION



Other Sedatives			
OTHER			
Over the Counter			

- 42. Have you ever overdosed? Y or N If yes, when_____ Was Narcan administered? Y or N
- 43. Have you participated in a substance use program in the past? Y or N If yes, location & year below:
- 44. Have you ever had a period of sobriety? Y or N; N/A If yes, how long? ______ If yes, why did you relapse?

LEGAL

- 45. Any current or pending legal issues, court cases, or charges? Including DCP&P? **Y** or **N** Explain:
- 46. Are you currently on probation or paroled? Y or N If yes, explain:

Name, address & phone number of Probation/Parole Officer:

- 47. Do you have an Advance Medical or Psychiatric Directive? Y or N If yes, who?
- 48. What would you like to accomplish in counseling?

By signing below, I acknowledge my answers are truthful and recalled to the best of my knowledge.

(Client Signature)

(Date)

(Parent/Guardian Signature if applicable)