ASSESSMENT SELF REPORT INFORMATION

	Last Name:											
Please let us know in detail what you	u need he	elp with (issues yo	u are experienc	cing):								
Please check all that apply:												
☐ Danger to Self ☐ Dang	ger to Oth	ers	Argumentative				Vic	ler	ıt			
	ressed		l Hallucinations			Delusions						
Paranoia Agita			Anxiety			H	Ma			,		
			•			_						
☐ Mood Swings ☐ Isola	ition		Obsessions				ım	pui	sive)		
Other:												
Family History of Mental Health a			None/Denies				_					
Who	M	lental Health / S				4	<u>Veç</u>					or You
		Mental Health				_	<u> </u>	Ye		<u> </u>		
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Your History of Mental Health Ser Service Type (Crisis Unit, Outpati		None/Denies Diagnosis or Issu	ΙΔ		0	utco	m	2 01	: Sc	rvice		
Residential, etc.)	ient, D	nagilosis or issu	е			Outcome of Service						
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Type of Substance Alcohol (beer, wine, and liquor)			Age When First Used									
Alcohol (beer, wifie, and liquor)							늗	-	es		No No	
								ו ו	CO	=		
Tobacco (cigarettes)							┢	ΙV	۵۵		N۸	
☐ Tobacco (cigarettes) ☐ Marijuana	·)						Ē	-	es	_	No No	
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Please check all that apply in each category:

Treatment Needs: Medication teaching Goal Setting Signs and symptoms of stress and anxi Signs and symptoms of depression Substance use (alcohol and/or drugs) Mental health concerns Lifestyle changes Daily living skills Wellness Care of physical illnesses /conditions Dynamics of chemical abuse Relapse prevention Trauma treatment Coping skills Domestic violence treatment Grief counseling Safety planning Relationship building Other:	ety	Community Needs: Referral to Medic Housing Legal Assistance Financial assistan Advanced Directi HIV/AIDS Resoun Transportation Employment Support groups Public Assistance Veteran resource Other:	al Doctor nce with medications ives rces
Strengths:	Abilities/Interests		Preferences:
I adhere to my medication plan I manage my health care needs I live independently I have a positive support system I am communicative I am financially stable I have a good sense of humor I am motivated I am spiritual I exercise regularly I make good grades I am respectful Other:	nere to my medication plan inage my health care needs is independently ive a positive support system communicative if inancially stable ive a good sense of humor immotivated is spiritual is pricise regularly is good grades in respectful I am athletic I have a good I l advocate for I have good so I l volunteer in I l am able to m I l empathize I have a hobb I manage mor I l am organize		Male Counselor Female Counselor Counselor not in recovery Counselor in recovery To live independently AM Appts PM Appts Not address substance use Not address mental health Not address physical concerns Medication management Individual therapy, not group Group therapy Community resources Religious/Spiritual considerations Auxiliary aids for hearing/seeing Other:
Do you have any Advanced Directives? Living Will Durable Power of Attorney Do Not Resituate Proxy Surrogate Medical Psychiatric	Yes No		
Patient/Guardian Signature:		Date:	:
ASSESSMENT SELF REPORT INFORMAT BC BH 1281	ION Rev. 6/14	P A T I E N T	