

ASSESSMENT SELF REPORT INFORMATION

First Name:	Last Name:
Please let us know in detail what you need help with (issues you are experiencing):	

Please check all that apply:

<input type="checkbox"/> Danger to Self	<input type="checkbox"/> Danger to Others	<input type="checkbox"/> Argumentative	<input type="checkbox"/> Violent
<input type="checkbox"/> Cutting Self	<input type="checkbox"/> Depressed	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions
<input type="checkbox"/> Paranoia	<input type="checkbox"/> Agitation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Mania
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Isolation	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Other: _____			

Family History of Mental Health and Substance Abuse None/Denies

Who	Mental Health / Substance Abuse	Negative Impact for You
	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No

Your History of Mental Health Services None/Denies

Service Type (Crisis Unit, Outpatient, Residential, etc.)	Diagnosis or Issue	Outcome of Service
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Your History of Substance Use None/Denies

Type of Substance	Age When First Used	Age When Last Used	Would you like to address in treatment?
<input type="checkbox"/> Alcohol (beer, wine, and liquor)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tobacco (cigarettes)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Marijuana			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Synthetics (spice, bath salts, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Inhalants (huffing)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hallucinogens (acid, mushrooms, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Stimulants (caffeine, speed, meth, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sedatives (xanax, valium, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Opiates (heroin, suboxone, methadone, roxy, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Crack/Cocaine			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tranquilizers (special k, etc.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No

Your History of Substance Use Services None/Denies

Service Type (Detox, Outpatient, Residential, etc.)	How Long in Treatment	Response to Treatment
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

If employed, how long have you been steadily employed (less than a month between jobs?) ____ years ____ months

Not employed

Please check all that apply in each category:

<p>Treatment Needs:</p> <input type="checkbox"/> Medication teaching <input type="checkbox"/> Goal Setting <input type="checkbox"/> Signs and symptoms of stress and anxiety <input type="checkbox"/> Signs and symptoms of depression <input type="checkbox"/> Substance use (alcohol and/or drugs) <input type="checkbox"/> Mental health concerns <input type="checkbox"/> Lifestyle changes <input type="checkbox"/> Daily living skills <input type="checkbox"/> Wellness <input type="checkbox"/> Care of physical illnesses /conditions <input type="checkbox"/> Dynamics of chemical abuse <input type="checkbox"/> Relapse prevention <input type="checkbox"/> Trauma treatment <input type="checkbox"/> Coping skills <input type="checkbox"/> Domestic violence treatment <input type="checkbox"/> Grief counseling <input type="checkbox"/> Safety planning <input type="checkbox"/> Relationship building <input type="checkbox"/> Other:	<p>Community Needs:</p> <input type="checkbox"/> Referral to Medical Doctor <input type="checkbox"/> Housing <input type="checkbox"/> Legal Assistance <input type="checkbox"/> Financial assistance with medications <input type="checkbox"/> Advanced Directives <input type="checkbox"/> HIV/AIDS Resources <input type="checkbox"/> Transportation <input type="checkbox"/> Employment <input type="checkbox"/> Support groups <input type="checkbox"/> Public Assistance <input type="checkbox"/> Veteran resources <input type="checkbox"/> Other:
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<p>Strengths:</p> <input type="checkbox"/> I adhere to my medication plan <input type="checkbox"/> I manage my health care needs <input type="checkbox"/> I live independently <input type="checkbox"/> I have a positive support system <input type="checkbox"/> I am communicative <input type="checkbox"/> I am financially stable <input type="checkbox"/> I have a good sense of humor <input type="checkbox"/> I am motivated <input type="checkbox"/> I am spiritual <input type="checkbox"/> I exercise regularly <input type="checkbox"/> I make good grades <input type="checkbox"/> I am respectful <input type="checkbox"/> Other:	<p>Abilities/Interests:</p> <input type="checkbox"/> I am creative <input type="checkbox"/> I am athletic <input type="checkbox"/> I have a good sense of humor <input type="checkbox"/> I advocate for myself <input type="checkbox"/> I have good social skills <input type="checkbox"/> I volunteer in my community <input type="checkbox"/> I have good parenting skills <input type="checkbox"/> I am able to manage time well <input type="checkbox"/> I empathize <input type="checkbox"/> I have a hobby <input type="checkbox"/> I manage money well <input type="checkbox"/> I am organized <input type="checkbox"/> I participate in sports/clubs <input type="checkbox"/> I enjoy reading <input type="checkbox"/> I enjoy writing/drawing <input type="checkbox"/> Other:	<p>Preferences:</p> <input type="checkbox"/> Male Counselor <input type="checkbox"/> Female Counselor <input type="checkbox"/> Counselor not in recovery <input type="checkbox"/> Counselor in recovery <input type="checkbox"/> To live independently <input type="checkbox"/> AM Appts <input type="checkbox"/> PM Appts <input type="checkbox"/> Not address substance use <input type="checkbox"/> Not address mental health <input type="checkbox"/> Not address physical concerns <input type="checkbox"/> Medication management <input type="checkbox"/> Individual therapy, not group <input type="checkbox"/> Group therapy <input type="checkbox"/> Community resources <input type="checkbox"/> Religious/Spiritual considerations <input type="checkbox"/> Auxiliary aids for hearing/seeing <input type="checkbox"/> Other:
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Do you have any Advanced Directives? Yes No

 Living Will
 Durable Power of Attorney
 Do Not Resituate
 Proxy
 Surrogate Medical
 Psychiatric

Patient/Guardian Signature: _____ Date: _____