



IDENTIFYING INFORMATION:

Name: _____ Today's Date: _____

Preferred Pronouns: _____ Date of Birth: _____ Age: _____

Self-identified Gender: _____ Sexual Orientation: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Secondary Language: _____

Ability to Read/Write? Yes No Special Accommodations: _____

Referred by/reason for referral: _____

In your own words what brings you in for services: _____

Are there any factors contributing to your presenting problem (i.e. work, family, finances, stressors, etc.) :

What is your perception of your current condition: _____

Current Providers (*Provider, provider location, date last seen, reason and frequency of care*)

Primary Care Provider _____
Psychotherapist/CNP _____
Psychotherapist _____
Case Manager _____
ARMHS _____
Probation Officer _____
Other _____

DIMENSION I: Acute Risk or Acute Intoxication/Withdrawal Potential

Risk of Harm

Have you recently had thoughts or wishes to harm yourself? No Yes, _____

Have you recently had thoughts of harming others? No Yes, _____

Do you have a history of self-harm or suicide attempts? No Yes, _____

Substance Use

No Yes Do you currently use any alcohol or illegal substances?

If yes, with what substances, when did they start and how often used? _____

No Yes Have you ever attended substance abuse disorder treatment?
If yes, where, and when? _____

No Yes Do you have any current or history of substance use withdrawal?
If yes, what symptoms were experienced and when? _____

No Yes Have relationships, social functioning, or work/school ever been affected by your substance use?
If yes, how had substance use had an impact on these areas? _____

DIMENSION II: Biomedical and Physical Health History

How would you rate your current physical health? Good Fair Poor

Are you experiencing any physical health concerns or have a current physical health diagnosis? _____

Have you experienced any of the following? (Please provide comments):

Traumatic Brain Injury: _____

Significant Illness That Affects Your Brain or Oxygen Level: _____

Exposure to A Sexually Transmitted or Blood Borne Diseases: _____

Are you or could you be pregnant: _____

Physical Health Disability: _____

Are you suffering any physical pain? No concerns with physical pain

Acute Pain (Identify Treatment Type Below) Chronic Pain (Identify Treatment Type Below)

Treatment Type:

Prescribed Pain Medication Home Remedies Other, Non-Pharmacological Approach

Over the Counter Medication Enrolled in Pain Management Program

Not Being Treated Physical Therapy Meditation Medical Referral Needed

Does your family engage in, or want to engage in any cultural healing practices? No Yes, _____

Current Medications: (Include OTC Medication and/or Herbal Supplements):

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Have you been prescribed mental health medications in the past? No Yes

Psychiatric Medication: _____ Dosage: _____ Frequency: _____

Psychiatric Medication: _____ Dosage: _____ Frequency: _____

Psychiatric Medication: _____ Dosage: _____ Frequency: _____

Do you have any known drug allergies? (If yes, please provide comments) No Yes

Do you have any nutritional concerns? (i.e. significant changes in weight, changes in appetite, dietary restrictions) _____

Do you need to establish services with a primary care provider or other medical professional? (If yes, please provide comments) No Yes

Additional Comments Regarding Your Current/Past Physical Health:

SUBSTANCE USE HISTORY:

| Primary Substance Used | Age of First Use | Most Recent Pattern of Use/Duration | Date/Time of Last Use | Withdrawal Potential? Needs Special Care? | Method of Use |
|--------------------------|------------------|-------------------------------------|-----------------------|---|---------------|
| Alcohol | | | | | |
| Amphetamines | | | | | |
| Barbiturates | | | | | |
| Benzodiazepines | | | | | |
| Cannabis | | | | | |
| Cocaine | | | | | |
| Crack | | | | | |
| Hallucinogens | | | | | |
| Heroin | | | | | |
| Inhalants | | | | | |
| Methamphetamine | | | | | |
| Nicotine | | | | | |
| Other | | | | | |
| Other Opiates/Synthetics | | | | | |
| Over the Counter Drugs | | | | | |

Have you ever been to detox or hospitalized for a substance use disorder? No Yes

If yes, where, and when? _____

Withdrawal Symptoms

| Symptom | Past 12 Months | Recent (Past 30 Days) |
|-------------------------------|----------------|-----------------------|
| Agitation | | |
| Anxiety/Worry | | |
| Confused/Disrupted Speech | | |
| Diarrhea | | |
| Diminished Appetite | | |
| Dizziness | | |
| Fatigue/Extremely Tired | | |
| Fever | | |
| Hallucinations | | |
| Headaches | | |
| High Blood Pressure | | |
| Irritability | | |
| Muscle Aches | | |
| Nausea/Vomiting | | |
| Paranoia | | |
| Psychosis | | |
| Sad/Depressed Feeling | | |
| Seizures | | |
| Sensitivity to Noise | | |
| Shakiness/Jitteriness/Tremors | | |
| Sweating and Rapid Pulse | | |
| Unable to Eat | | |
| Unable to Sleep | | |
| Vivid/Unpleasant Dreams | | |
| Other | | |

Is there anything else you would like us to know regarding your substance history or withdrawal symptoms?

DIMENSION III: Emotional/Behavioral/Cognitive

Family Status/Psychosocial History

Please explain what life was like growing up in your family (*Family history, including parental marital status, who you were raised by, number of siblings, presence of abuse/neglect, and any other significant information*).

EDUCATIONAL HISTORY:

Where did you go to school? What was your experience with school growing up?

Any developmental incidents? Unremarkable Delayed Milestones Atypical Other _____

Current/Highest Level of Education: _____

Did you receive any special educational services (IEP, 504, Title 1) or have special educational needs?

No Yes, _____

Do you have any concerns with learning disabilities? _____

FAMILY HISTORY: Do you have any relatives (including parents, grandparents, aunts, uncles, or cousins) who have any of the following conditions?

| | Relationship | | Relationship |
|-----------------------------------|--------------|--------------------------------|--------------|
| ADHD/ADD | | Eating Disorders | |
| Alcohol or Drug Problems | | Learning Disorders | |
| Anxiety/OCD | | Mental Health Hospitalizations | |
| Autism/Autism Spectrum Disorder | | Nerve Problems | |
| Bipolar Disorder | | Personality Disorders | |
| Brain Damage | | Physical Abuse | |
| Chronic Pain | | PTSD | |
| Completion of or Suicide Attempts | | Schizophrenia | |
| Convulsions/Seizures | | School Problems | |
| Dementia | | Sexual Abuse | |
| Depression | | Thyroid Problems | |
| Developmental Delays | | Tic/Tourette’s Disorder | |
| Domestic Violence | | Other | |

PAST MENTAL HEALTH SERVICES:

AHRMS/Case Management Services: _____

Mental Health/Substance Use Hospitalizations: _____

Partial Hospitalization Program: _____

Previous Mental Health Diagnosis: _____

Psychiatric Care: _____

Psychological Testing: _____

Psychotherapy: _____

Other: _____

Do you currently have a diagnosis, or have you ever had a diagnosis of a mental health or substance use disorder? No

Yes, _____

Have you ever been hospitalized due to mental health or substance use? If yes, please explain when and where: No

Yes, _____

Are you currently or have you ever received any other mental health or substance use treatment? If yes, please explain

when and where: No Yes, _____

If you are currently taking medication to manage your mental health, are they adequately managing/stabilizing mental

health symptoms? No Yes

CURRENT SYMPTOMS: Please check the follow symptoms you are currently experiencing and elaborate on how often and long this has been a problem.

Addictive Behavior

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|-------------------|---|
| | Computer/Gaming | |
| | Exercise/Fitness | |
| | Gambling | |
| | Sexual Activity | |
| | Shopping/Spending | |
| | Other | |

Anxiety

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|---------------------------------------|---|
| | Anxiety Around Others | |
| | Anxiety/Worry | |
| | Compulsions (Unwanted Behaviors) | |
| | Difficulty Breathing | |
| | Fears/Phobias | |
| | Muscle Tension/Headaches/Stomachaches | |
| | Obsessions (Unwanted Thoughts) | |
| | Panic Attacks | |
| | Racing Thoughts | |
| | Restlessness | |
| | Other | |

Behavior and Attention

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|---------|---|
|------------------|---------|---|

| | | |
|--|----------------------------|--|
| | Aggressive Behaviors | |
| | Anger Concerns | |
| | Concentration Problems | |
| | Easily Bored/Impatient | |
| | Easily Distracted | |
| | Excessive Energy | |
| | Impulse Control Problems | |
| | Lying | |
| | Memory Problems | |
| | Stealing | |
| | Thoughts of Harming Others | |
| | Other | |

Mood

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|--------------------------------------|---|
| | Crying Spells | |
| | Fatigue/Loss of Energy | |
| | Feelings of Worthlessness | |
| | Guilt | |
| | Irritability | |
| | Low Motivation | |
| | Mood Swings | |
| | Negative Beliefs/Thoughts About Self | |
| | Reduced Interest/Enjoyment | |
| | Sad/Depressed Mood | |
| | Thoughts of Harming Self | |
| | Other | |

Nutrition

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|------------------------------|---|
| | Appetite/Weight Changes | |
| | Self-Starving | |
| | Severe Overeating | |
| | Significant Weight Loss/Gain | |
| | Vomiting After Eating | |
| | Other | |

Trauma

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|---|---|
| | Avoidance of Certain People/Places/Things | |
| | Difficulty Initiating Sleep | |
| | Disrupted Sleep | |
| | Flashbacks | |
| | Hypervigilant | |

| | | |
|--|---|--|
| | Inability to Experience Positive Emotions | |
| | Intrusive Thoughts | |
| | Jumpy/Startles Easily | |
| | Nightmares | |
| | Sleep Problems | |
| | Other | |

Psychosis

| Check if Applies | Symptom | Describe (Include how long and how often) |
|------------------|--|---|
| | Believe or Believed Others Were Controlling Your Thoughts/Plotting Against You | |
| | Believe or Believed You Have Special Powers | |
| | Feeling/Hearing/Seeing/Smelling Things That Aren't Really There | |
| | Sexual Concerns/Problems | |
| | Sexual Identity Concerns/Problems | |
| | Other | |

Adverse Events

Have you experienced any events of maltreatment, physical, emotional, sexual abuse, or neglect in childhood or as an adult?

Have you experienced or been part of a group that experienced community violence or historical trauma?

Are there any other symptoms or issues that you think it would be helpful for us to know about?

DIMENSION IV: Readiness for Change

How would you describe your current concerns related to your mental health to family, friends, or others in the community?

What causes you the most difficulties regarding your current concerns? Has anything helped with those concerns in the past?

What kinds of help would be the most useful to you at this time, and are you open to making these changes?

DIMENSION V: Relapse, Continue Use/Problem Potential

What would you identify as your personal strengths?

What would you identify as your personal challenges?

DIMENSION VI: Recovery Environment

Current Living Situation Do you feel safe in your current living environment? No Yes If no, please feel free to communicate further at time of evaluation with a mental health professional.

Please describe your current living situation (Include length of residency, household members or status of current housing). _____

Are you currently, or have you ever served in the military? If yes, please share what branch and years of service:

No Yes, _____

Employment/Financial

Current and Previous Employment: _____

Any concerns with meeting your basic needs or accessing services: _____

Current Financial Difficulties or Strain: _____

LEGAL:

Have you in the past, or are you currently working with Child Protective Services? No Yes

Please provide details on social workers involved, dates of involvement, etc. _____

Are you currently on probation, parole, and/or involved with a specialty court program? No Yes
Please provide details on probation officers involved, dates of involvement, etc.

Have you been arrested or had any legal interactions? _____

SUPPORTS:

What significant relationships do you have in your life right now? _____

How would you currently describe the quality of your current relationships (with significant other, children, others)

Do you have supports that you want to participate in your treatment at this time? _____

Do you have any children that live with you? No Yes That do not live with you? No Yes

CULTURAL/SPIRITUAL:

Do you have any spiritual, or other types of belief systems, that are important to your recovery?

Do you have any cultural practices that are important for your recovery?

Thank you for taking the time to fill out this questionnaire.