Stepping Stones Counseling, PLLC

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Biopsychosocial Assessment

IDENTIFYING INFORMATION

Name_____ Maiden_____ SS#_____ Date_____
Address_____ _____
Street or PO Box City State Zip How long at this address?
Home Phone_____ Cell_____ Work:_____ e-mail _____
DOB_____ Gender: ____ Race: _____ Tribe: _____Ethnicity:_____
Marital Status: ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed
☐ Married (including Common Law) ☐ Never Married (including annulled)
Years of Education Completed_____ Degree_____ Field_____ GED? _____
Employer_____ Job Title _____ Supervisor _____
Name Phone
Employer Address_____
Street or PO Box City State Zip Phone
Family Contact Person_____ Relationship to you_____
Address_____ Phone #_____
Are you court-ordered or have you been recommended for treatment? ☐No ☐Yes
If yes, who recommended treatment? _____
Describe your reasons for seeking treatment services at this time_____
_____

SUBSTANCE USE HISTORY
Do you have the desire to stop using drugs and/or alcohol? ☐No ☐Yes ☐Maybe
Explain: _____
What is (are) your drug(s) of choice? _____
On the average, how often (frequency) do you use? _____
On the average, how much (quantity) do you use? _____
How much does it take for you to feel a buzz or to get high? _____
Have you ever used IV drugs? ☐No ☐Yes If yes, what?_____
_____
What was the date of your last IV use? _____
Have you shared needles/rigs? Yes _____ No ____
Have you been diagnosed with HIV? Yes _____ No ____
Have you been diagnosed with HEP C? Yes _____ No ____
What consequences have you experienced as a result of your use of alcohol and/or chemicals? _____
_____
_____
Have you been in a controlled environment in the last 30 days? ☐No ☐Yes How many days? _____
☐ Jail ☐ Alcohol/Drug Treatment
☐ Medical Treatment ☐ Psychiatric Treatment
☐ Other _____
How long has chemical use been a problem for you? _____
Describe your reasons for drinking and/or using drugs. Be specific._____
_____

What reasons would make you want to quit drinking and/or using drugs? _____
_____

When you use, do you: ☐ Always use with others ☐ Mostly use with others
☐ Mostly use alone ☐ Alone & with others about equally Using the following numbers, please complete the chart below:

Route

1 = Oral
2 = Nasal (sniffing)
3 = Smoking
4 = Intramuscular
5 = Intravenous
6 = Other:_____

Severity of Problem

0 = Not a problem
1 = Primary
2 = Secondary
3 = Tertiary

Frequency of Use

0 = No use
1 = 1-3 times in lifetime
2 = 1 time per month
3 = 2-3 times per month
4 = Once per week
5 = 2-6 times per week
6 = 1 time per day
7 = 2-3 times per day
8 = 4+ times per day

	SUBSTANCE	SEVERITY OF PROBLEM	AGE AT FIRST USE	DATE OF LAST USE	ROUTE	AMOUNT USED	CURRENT FREQUENCEY PREVIOUS 30 DAYS	FREQUENCY PAST 6 MONTHS
1	Alcohol							
2	Cocaine/Crack							
3	Marijuana							
4	Heroin							
5	Non-Rx Methadone							
6	Opiates (methadone, lortab, oxy)							
7	PCP (Angel Dust)							
8	Hallucinogens (Acid, Mushrooms)							
9	Methamphetamine							
10	Other Amphetamine (Speed, Crank)							
11	Other Stimulants							
12	Benzodiazepine (Xanax, Valium)							
13	Other Tranquilizers							
14	Barbiturates (Nembutal, Seconal)							
15	Other Hypnotics (Ambien, Klonopin)							
16	Inhalants (Gas, Glue, etc.)							
17	Over the Counter							
18	Other - Identify							
19	Tobacco							
20	Caffeine							

List activities at which you use or drink and check whether usually or sometimes:

Activity	Usually	Sometimes

How has your use of alcohol or drugs affected these areas of your life? Check all that apply.

Area of Life	Has caused no problems	Has caused some problems	Has caused a lot of problems
Family			
Friends			
Legal/Law			
Jobs			
School			
Financial			
Health			
Emotional			
Spiritual			

Dimension I – Acute Intoxication/Withdrawal Potential

Behavioral Aspects of Chemical Use

Have you ever drank or used in the morning?	☐ No	☐ Yes
Do you miss meals when you are drinking or using?	☐ No	☐ Yes
Do you drink or use alone?	☐ No	☐ Yes
Have you ever had a blackout?	☐ No	☐ Yes
Do you sometimes get the shakes after a night of heavy drinking or using?	☐ No	☐ Yes
Do you have difficulty sleeping?	☐ No	☐ Yes
Do you quarrel or fight with others when drinking or using?	☐ No	☐ Yes
Have you ever drank or used on the job?	☐ No	☐ Yes
Do you drink or use while doing your normal daily activities?	☐ No	☐ Yes
Have you ever missed work or important activities due to drinking or using?	☐ No	☐ Yes
Have you ever had hallucinations or the DT's after drinking or using?	☐ No	☐ Yes
Do you sometimes lose control when drinking or using?	☐ No	☐ Yes
Do you tend to make impulsive decisions when drinking or using?	☐ No	☐ Yes
Have you ever been told by a doctor that you need to quit drinking or using?	☐ No	☐ Yes
Have you had an illness that is caused or made worse by drinking or using?	☐ No	☐ Yes

Have you used any alcohol/other drugs in the past two weeks? ☐No ☐Yes
If "yes" please indicate the following:

What	How Much	Last Use

Have you ever experienced any kind of withdrawal symptoms after stopping alcohol/other drug use? ☐No ☐Yes

☐ Agitation	☐ Hurried Ingestion	☐ Muscle Aches	☐ Hiding/Sneaking
☐ Anxiety	☐ Hallucinations	☐ Nausea/Vomiting	☐ Unpleasant Dreams
☐ Cravings	☐ Hand Tremors	☐ Memory Lapses	☐ Inability to Concentrate
☐ Seizures	☐ Body Tremors	☐ Sleep problems	☐ Decreased Appetite
☐ Fatigue	☐ Accidents	☐ Depressed Mood	☐ Increased Appetite
☐ Aggression	☐ Sweating	☐ Guilt over use	☐ Periodic Abstinence

Description questions:

1. Following the use of which chemicals did you experience withdrawal symptoms? _____
2. How long did the symptoms last? _____
3. Did you need or receive medical attention? ☐No ☐Yes If so, what kind?_____

Have you used alcohol/other drugs until you have passed out or had a "black out"? ☐No ☐Yes
If "yes", when: _____

Are you currently feeling physically ill because of your alcohol/other drug use? ☐No ☐Yes
If "yes", what are your symptoms now? _____

Have you overdosed on alcohol/other drugs? ☐No ☐Yes
If "yes", when: _____

Were you hospitalized as a result? ☐No ☐Yes
If "yes", when and where: _____

Have you been detoxified in a hospital or other setting from alcohol/other drugs? ☐No ☐Yes
If "yes", when and where: _____

GAMBLING HISTORY

How often do you gamble? _____

Describe any problems gambling has caused in your life _____
_____

Have you had significant gambling losses? ☐No ☐Yes Explain_____
_____

How does gambling relate to your chemical use? _____
_____

Counselor's Comments

_____
_____
_____
_____
_____

Dimension II – Biomedical Conditions/Complications

How would you rate your general physical health over the last six (6) months?
☐ Excellent ☐ Good ☐ Fair ☐Poor

When and for what reason did you last see a doctor? _____
_____

Describe your current medical conditions or problems_____
_____

Describe any past medical problems, injuries and/or surgeries_____
_____

Have you ever had a traumatic head injury? ☐No ☐Yes If yes, describe_____
_____

List all medications you have taken during the past year including over-the-counter medications
_____
_____

Do you have any allergies? ☐No ☐Yes If yes, what? _____
_____

Describe any chronic pain you have_____
_____

Did your birth mother drink or use drugs while pregnant with you? ☐No ☐Yes Describe:_____

_____

Describe your normal eating patterns_____

_____

_____

Do you have a history of dieting? ☐No ☐Yes If yes, explain:_____

_____

Are you generally satisfied with your weight/appearance? ☐No ☐Yes If no, explain:_____

_____

What is your present weight? ____ Height? ____ What is your highest weight since puberty? ____ Lowest? _____

Do you have trouble sleeping? ☐No ☐Yes Explain: _____

_____

Have you ever had any of the following conditions? (Check all that apply):

☐ Ulcers	☐ Diabetes	☐ Hepatitis
☐ Heart Trouble	☐ High Blood Pressure	☐ Stroke
☐ Allergies	☐ Anemia	☐ Epilepsy
☐ Hearing Problems	☐ Cirrhosis	☐ Convulsions/Seizures
☐ Hyperactivity/ADHD	☐ Nervousness	☐ Depression
☐ Attempted Suicide	☐ Eyesight Problems	☐ Alcohol/Drug Problems
☐ Hypoglycemia	☐ Bleeding Tendencies	☐ Headaches/Migraines
☐ HIV (AIDS)	☐Other (specify): _____	

How many days in the past 30 days have you experienced medical problems? _____

How troubled or bothered have you been in the past 30 days by these medical problems?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

How important to you now is treatment for these medical problems?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Do you have any health issues related to your use of alcohol/other drugs? ☐No ☐Yes If "yes", please explain:

_____

Do you have current medical providers? ☐No ☐Yes

If no, do you need one? ☐No ☐Yes

If "yes", please list either the clinic name or the physician: _____

_____

Are you or do you suspect that you are pregnant? ☐No ☐Yes

If "yes", when is the baby's due date? _____

Name of physician overseeing pregnancy: _____

# of pregnancies____ # of miscarriages____ # of abortions____ # of adoptions____

Any complications during pregnancies/deliveries? ☐No ☐Yes

If "yes", please explain: _____

Do you have a disability? ☐No ☐Yes

If "yes", please indicate: ☐Reading ☐Learning ☐Psychiatric ☐Physical ☐Other

If Other, please explain: _____

Have you ever needed reasonable accommodation for the above? ☐No ☐Yes

If "yes", please explain: _____

Counselor's Comments

_____

_____

_____

_____

Dimension III – Emotional/Behavioral/Cognitive Conditions/Complications

Have you been prescribed medication for any psychological or emotional problems? ☐No ☐Yes
If yes, please list all medications prescribed during the past 5 years: _____
_____
Have you ever been referred for mental health counseling? ☐No ☐Yes
If yes, where and when were you referred? _____
Are you currently taking psychiatric medications? ☐No ☐Yes
If "yes", please list psychiatric medications that you are currently taking: _____
_____
Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? ☐No ☐Yes If "yes", please list when and where services were received (and providers):
_____
_____
In the past 30 days, have you had a significant period of time in which you have experienced serious depression? ☐No ☐Yes If "yes", please explain:_____
In the past 30 days, have you had a significant period of time in which you have experienced anxiety or tension? ☐No ☐Yes If yes, please explain:_____
Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? ☐No ☐Yes If "yes", please list when and where services were received (and providers):_____
_____
Have you ever been diagnosed with any of the following mental health disorders?

☐ Alcoholism	☐ Gambling Addiction	☐ Fetal Alcohol Syndrome/Effect
☐ Drug Dependency	☐ Schizophrenia	☐ Eating Disorder
☐ Bi-polar	☐ Anxiety	☐ Sexual Disorders
☐ Depression	☐ Panic Attacks	☐ Obsessive Compulsive Disorder
☐ Nervous Breakdown	☐ Hyperactivity (ADHD, ADD)	☐ Other:_____

Have you ever been seen in an emergency room or been hospitalized for psychiatric reasons? ☐No ☐Yes
If "yes", please list when and where services were received (and providers):_____
_____
Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? ☐No ☐Yes
If yes, please explain: _____
In the past 30 days, have you had a significant period of time in which you have experienced hallucinations (heard voices no one else could hear or see objects or things which others could not see)? ☐No ☐Yes
If yes, please explain: _____
_____
Have you ever had nightmares or flashbacks as a result of being involved in some traumatic or terrible event? For example: warfare, gang fights, domestic violence, rape, incest, car accident, being shot or stabbed. ☐No ☐Yes
If yes, please explain: _____
_____
In the past 30 days, have you had a significant period of time in which you have experienced trouble controlling violent behavior? ☐No ☐Yes If yes, please explain:_____
_____
Have you ever given in to an aggressive urge or impulse on more than one occasion that resulted in serious harm to others or led to destruction of property? ☐No ☐Yes
If "yes", please explain: _____
_____

Have you ever felt that people had something against you without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors? ☐No ☐Yes
If yes, please explain: _____
Have you ever had a period of time when you were so full of energy and your ideas came very rapidly when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? ☐No ☐Yes
If yes, please explain: _____
_____
Have you ever had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady as if you would faint? ☐No ☐Yes If yes, please explain: _____
_____
Have you ever experienced any strong fears? For example: of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? ☐No ☐Yes
If yes, please explain: _____
_____
Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, or maintaining a very rigid schedule of daily activities from which you could not deviate? ☐No ☐Yes
If yes, please explain:_____
_____
In the past 30 days, have you had a significant period of time in which you have experienced trouble understanding, concentrating or remembering? ☐No ☐Yes If yes, please explain:_____
_____
How many days in the past 30 days have you experienced psychological or emotional problems?_____
How troubled or bothered have you been in the past 30 days by psychological or emotional problems?
☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely
How important to you now is treatment for these psychological or emotional problems?
☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely
Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? ☐No ☐Yes If yes, please describe:_____
_____
_____
Have you had any personal crises in the past year (death in family, other losses, severe illness, etc.)? ☐No ☐Yes
Event:_____ Date:_____
Describe the three most traumatic events you have experienced in your lifetime:
Event:_____ Date:_____
Event:_____ Date:_____
Event:_____ Date:_____
Have you ever been a victim of a violent or non-violent crime? ☐No ☐Yes If yes, please explain:_____
_____
Have you ever engaged in violent or combative behavior? ☐No ☐Yes If "yes", please explain:_____
_____
Have you ever had thoughts of harming someone else? ☐No ☐Yes If "yes", please explain:_____
_____
Have you caused harm to yourself (i.e., cutting, burning, oxygen deprivation, etc.)? ☐No ☐Yes
If yes, please describe how and when this occurred:_____
_____

Have you ever had suicidal thoughts? ☐No ☐Yes When:_____
At any time, did those thoughts include a plan? ☐No ☐Yes If yes, please give specifics:_____
_____
Have you made any suicide attempts? ☐No ☐Yes If yes, please list when and how:_____
_____
In the past 30 days, have you had a significant period of time in which you have experienced serious thoughts of suicide? ☐No ☐Yes If yes, please explain:_____
_____
In the past 30 days, have you had a significant period of time in which you have attempted suicide? ☐No ☐Yes
If yes, please explain:_____
_____
Do you get easily upset when you area teased or criticized? ☐No ☐Yes If "yes", please explain:_____
_____
Do you get uncomfortable or nervous when meeting new people or when around a lot of people? ☐No ☐Yes
If "yes", please explain:_____
_____
Has any member of your family ever had the following conditions:

Condition	**Family Member**
Alcoholism	_____
Anxiety Disorder	_____
Attempted Suicide	_____
Bi-Polar	_____
Depression	_____
Drug Dependency	_____
Eating Disorder	_____
Fetal Alcohol Syndrome/Effect	_____
Gambling Addiction	_____
Hyperactivity (ADHD, ADD)	_____
Nervous Breakdown	_____
Obsessive Compulsive Disorder	_____
Other Mental Health Problem	_____
Panic Attacks	_____
Schizophrenia	_____
Self-Harm Behaviors	_____
Sexual Disorders	_____
Suicide (ideation or plan)	_____

Do you experience mood swings? ☐No ☐Yes If yes, explain:_____
_____
_____
Describe your past and present involvement with mental health professionals/services._____
_____
_____
What were your concerns and/or diagnosis? _____
_____
Describe significant losses you have had in your life (death, abortion, divorce, miscarriage, job, health, school, etc.)
_____
_____
How do you normally handle stress? _____
_____

Describe any childhood trauma and/or abuse that you experienced_____
_____
_____
_____

Has any member of your family had emotional/behavioral problems or been diagnosed with a mental illness?
☐No ☐Yes Explain:_____
_____

Do you ever have problems with any of the following? (Check all that apply)

- ☐ Memory
- ☐ Hearing voices
- ☐ Suicidal thoughts
- ☐ Feeling disoriented
- ☐ Overwhelming sadness
- ☐ Impulsive behavior
- ☐ Unknown fears
- ☐ Uncomfortable thoughts
- ☐ Bright lights hurt your eyes
- ☐ Urge to kill someone
- ☐ Confusion
- ☐ Inability to concentrate
- ☐ Anger/Rage
- ☐ Ability to express yourself

SEXUAL HISTORY

Age sexual activity began_____ Frequency_____
Sexual Orientation: ☐Opposite Sex ☐Same Sex ☐Both Sexes ☐Multiple Partners
Have you experienced any physical and/or sexual abuse? ☐No ☐Yes If yes, explain:_____
_____
_____

Have you physically or sexually abused others? ☐No ☐Yes If yes, explain:_____
_____
_____

Have you had sexual experiences that caused you to feel guilt, shame or painful feelings? ☐No ☐Yes
If yes, explain:_____
_____

How would you describe your current sexuality? _____
_____

Dimension IV – Readiness to Change

Do you believe you have a problem with alcohol/other drugs? ☐No ☐Yes
Do you believe you have alcoholism/addiction? ☐No ☐Yes
How do you define alcoholism/other drug addiction?_____
_____

Have you ever been diagnosed with a substance abuse disorder? ☐No ☐Yes
If "yes", by whom and when: _____
Have you received chemical dependency treatment in the past? ☐No ☐Yes
Counseling/Treatment History:

When	Where – Name/City	Outcome	How Long Sober?

What are your thoughts about treatment? _____
_____
_____

Have you ever attended a Recovery Support program (ie. AA, NA, Secular Sobriety)? ☐No ☐Yes

Where, when, what group?_____

_____

What are your thoughts and feelings about participating in a Recovery Support program? _____

_____

Do family members or friends express concerns to you about your alcohol/other drug use? ☐No ☐Yes

If "Yes" what do you think about their concerns?_____

_____

How many days in the past 30 days have you experienced alcohol related problems (i.e., economic, relationship, health)?_____

How troubled or bothered have you been in the past 30 days by these alcohol problems?

☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely

Do you think you need to stop using alcohol? ☐No ☐Yes

Please explain: _____

_____

How important to you now is treatment for these alcohol problems?

☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely

Do you think you need to stop using drugs? ☐No ☐Yes

How troubled or bothered have you been in the past 30 days by these drug problems?

☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely

What negative life consequences or impact has your alcohol/other drugs use produced?_____

_____

Do you believe you can recover on your own? ☐No ☐Yes

If "yes", please explain:_____

Are you willing to make changes in your life? ☐No ☐Yes

If "yes", please explain:_____

As honestly as you can, please describe your willingness to do the following:

	Yes, I Want To	Yes, If I Have To	Not At All
Abstain from chemical use throughout treatment	☐	☐	☐
Attend group/individual therapy sessions from 1-3x/wk	☐	☐	☐
Submit to random chemical use testing	☐	☐	☐
Attend a self help or recovery support group at least 1x/wk	☐	☐	☐

What do you want out of addiction treatment? _____

What problems/situations do you feel might affect your ability to fully participate in treatment?_____

_____

What do you like the best about yourself? _____

_____

What do you like the least about yourself? _____

Dimension V – Relapse/Continued Use/Continued Problem Potential

I am most likely to use alcohol and/or drugs when . . . (Check all that apply).

☐ I'm hungry	☐ I'm tired	☐ I'm lonely
☐ I'm angry, frustrated, etc.	☐ I'm confused	☐ I'm happy
☐ I'm sad, depressed, etc.	☐ I'm around family	☐ I'm with friends
☐ I want to have fun	☐ I want sex	☐ Anytime – I like to drink or use

How many times have you attempted to cut down or quit only to start using again? _____

What is the longest period of sobriety that you have had? _____

What were the circumstances that led you to start drinking or using again? _____

_____

Do you often find yourself thinking about using alcohol/other drugs? ☐No ☐Yes
If "yes", please explain:_____
How often do you experience cravings (longing for, looking forward to) alcohol/other drugs?
☐Often ☐Sometimes ☐Never
Please describe:_____
Do you tend to use alcohol/other drugs impulsively (without planning)? ☐No ☐Yes

Are you experiencing any significant problems in your life at this time? ☐No ☐Yes
If “yes”, please check areas below and give a brief explanation:
☐Family ☐Medical ☐Emotional/Psychological
☐Relationship ☐Employment ☐Housing
☐Recent Loss ☐Financial ☐Other Crisis
Please explain:_____
_____
Do you believe these problems might cause you to drink or use any mood-altering substances? ☐No ☐Yes
If "yes", please explain:_____
In order to stay sober, would you need to avoid being around certain people or places? ☐No ☐Yes
Please describe_____
How difficult would it be for you to avoid these people or places?
☐ Impossible ☐ Very difficult ☐ Somewhat difficult ☐ Not difficult at all
If you return and/or continue to use what consequences will occur?_____
_____
Do you have other addictive behaviors? (i.e., gambling, spending, sexual acting out, masturbation, pornography, overeating, problem relationships)? ☐No ☐Yes If "yes", please explain:_____
_____

Dimension VI – Recovery Environment

Briefly describe your family atmosphere while growing up (i.e., Who raised you? Where? etc.) _____
_____
_____
_____
_____
_____
Relationship History/Family of Origin (Briefly describe significant aspects of each)
Mother_____
_____
Father_____
_____
Other Adult Role Models (Foster parents, grandparents, etc) _____
_____
Siblings_____
_____
Relationship History/Peer Groups (briefly describe your friendships, include your drinking/using patterns/behavior)
Childhood_____
_____
Teenager_____
_____
Young Adult_____
_____

Current intimate partner_____ Length of relationship_____
Does your Spouse/Significant Other use chemicals? ☐Yes ☐No If yes, describe_____
_____
_____
Will your Spouse/Significant Other support you in your recovery efforts? ☐Yes ☐No
Describe your current relationship, especially the past two years, making note of problems_____
_____
_____
If you are in a relationship are there any changes you would like to see happen?_____
_____
_____

Intimate Relationships

Dates of Relationships	Name of Spouse/Partner	How did it end?

Family Structure – list family members and significant others in your life

Name	Relationship	Age	Your relationship with them (Good/Fair/Poor)	Aware of your chemical use? Yes/No	Does he/she use alcohol or drugs? Yes/No/In Recovery

Are any of the people listed willing to support your treatment and recovery efforts? ☐No ☐Yes
Who:_____
Children:

Name of Child	Age	Father/Mother	If under 18, who has Custody?

Describe your relationship with your children_____
_____
How has your chemical use impacted your partner, children and other family members?_____
_____
Does your current living situation make it difficult to work on recovery from an alcohol/drug problem? ☐No ☐Yes
If "yes", in what ways?_____
Describe your current social relationships_____
_____
Have you ever participated in a community club or organization? ☐ No ☐ Yes If yes, what? _____
_____
How many days in the past 30 days have you experienced family problems?_____

How troubled or bothered have you been in the past 30 days by family problems?

☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely

How important to you now is treatment for these family problems?

☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely

In the past 30 days, have you had significant periods in which you have experienced serious problems getting along with:

	N/A	No	Yes		N/A	No	Yes
Mother	☐	☐	☐	Close Friends	☐	☐	☐
Father	☐	☐	☐	Neighbors	☐	☐	☐
Brothers/Sisters	☐	☐	☐	Co-workers	☐	☐	☐
Partner /Spouse	☐	☐	☐	Other Significant Family	☐	☐	☐
Children	☐	☐	☐				

If "yes" to any of the above, please explain: _____

_____

Does your family understand alcoholism/drug dependency? ☐No ☐Yes

Do your important friends understand alcoholism/drug dependency? ☐No ☐Yes

Does your family encourage you to abstain from alcohol/other drugs? ☐No ☐Yes

Do your friends encourage you to abstain from alcohol/other drugs? ☐No ☐Yes

Do you have contact with friends or family who do not use alcohol/other drugs? ☐No ☐Yes

If "yes", who:_____

Do you use friends and family members for support? ☐No ☐Yes

If "yes", who and how?_____

Do you have serious problems with your family, friends or on the job that could interfere with your staying clean and/or sober? ☐No ☐Yes

If "yes", please explain:_____

To what extent do your contacts with friends involve the use of alcohol/other drugs?

☐Always ☐Nearly always ☐Sometimes ☐Infrequently ☐Not at all

EDUCATIONAL/VOCATIONAL

What is the highest grade you've completed, including college? _____

Do you have a High School Diploma or GED? ☐ No ☐ Yes

H.S. Diploma___ Year_____ Name of school_____

GED____ Year_____ Name of school or city_____

Describe your relationships with teachers and other authority figures_____

_____

Relationship with peers and friends_____

_____

Did you use drugs and/or alcohol during your school years? ☐ No ☐ Yes If yes, explain:_____

_____

Please list university, college, vocational school, technical school or training program attended.

Name of School or Training Program	Location	Dates Attended	Major or Field of Study	Degree/Certificate Received

What are your educational goals? _____

_____

MILITARY HISTORY

Were you ever in the military? ☐No ☐Yes

Branch_____ Date Enlisted_____ Date Discharged_____

Type of Discharge_____ Rank at Discharge_____

Describe your military experience including combat duty, medical/psychological problems, disciplinary problems, relationships with senior personnel and peers_____

_____

Did drug or alcohol use affect your service or discharge? ☐No ☐Yes

If "yes", please explain:_____

_____

EMPLOYMENT HISTORY

Employer Name and City	Position	Dates Employed	Reason for Leaving

What job did you like the most? _____

What did you like about this job? _____

_____

What job did you like the least? _____

What didn't you like about this job? _____

_____

Describe your work environment including your relationships with superiors and co-workers, problems, injuries and job performance_____

_____

_____

_____

Did you work while under the influence of drugs/alcohol?

☐Never ☐Sometimes ☐Often ☐Always/Almost Always

What are your career/employment goals? _____

_____

_____

Does your job put you in situations where it is very difficult to avoid drinking/using? ☐No ☐Yes

If "yes", please explain:_____

If employed, do your co-workers support you having a sober lifestyle? ☐No ☐Yes

How will your employment or lack of employment impact recovery?_____

_____

Have you lost or experienced any work related problems due to your use of alcohol/other drugs? ☐No ☐Yes

If "yes", please explain:_____

Are you experiencing any financial difficulties at this time? ☐No ☐Yes

If "yes", please explain:_____

_____

How many jobs have you held in the past 5 years?_____

Describe your reasons for leaving/changing jobs: _____

_____

_____

RECREATION / LEISURE ACTIVITIES

Describe your pastimes, recreation and leisure activities: _____

_____

What are your favorite outdoor activities? _____

What are your favorite indoor activities? _____

To what extent do your recreational activities involve the use of alcohol and/or other drugs?

☐Always ☐Usually ☐Sometimes ☐Rarely ☐Never

CRIMINAL HISTORY

Probation Officer:

Name:_____ City:_____ Phone:_____ Cell:_____

DOC ID# (If applicable):_____ Current Legal Charges:_____

Sentenced to:_____ Date Sentenced:_____

Are you required to register as a Sex Offender: ☐No ☐Yes Violent Offender: ☐No ☐Yes

At what age did you begin criminal activity? _____

Is there a history of criminal activity in your family? ☐No ☐Yes If yes, explain_____

_____

How is your criminal activity related to your chemical use? _____

_____

Describe your criminal activity as an adult (List all arrests, convictions, sentence, jail/prison time, revocations, etc.):

_____

_____

_____

_____

_____

_____

Have you ever been convicted of DUI?_____ If yes, how many times?_____

List dates and locations of DUI convictions:_____

_____

Describe in detail the events that preceded your DUI (include the date you were arrested, what you were doing that day, how many drinks you had, if you were using any other drugs or medications, why you were stopped, your BAC)

_____

_____

_____

_____

_____

CULTURE/SPIRITUALITY

Describe your spiritual beliefs. _____

_____

What do you value? _____

_____

Describe the ethnic and cultural background that has influenced your values and belief system.

_____

Discuss your history of religious development, church affiliations and/or current involvement.

_____

How has your chemical use affected your spirituality?_____

_____

_____

If you stopped drinking/using drugs, would your life be:

( )Greatly improved ( )Somewhat improved ( )Unchanged ( )Worse

Explain _____

_____

Notice of Confidentiality: I understand that the information I have provided is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 42 U.S.C.§ 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____

Patient Signature Date Parent/Guardian (if minor) Date

_____ _____

Counselor Signature Date Reviewed