

PERSPECTIVES OF TROY, P.C.

ADULT

Dx _____

SCREENING INFORMATION

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Readmit: __Yes __No

Date _____ Client's Social Security # _____ Case # _____

Client's Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Ok to leave messages? Home: __yes __no Work: __yes __no Cell: __yes __no

Birthdate ____/____/____ Age _____ Gender __F __M Race _____

Email address (used for marketing purposes only): _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Other Physician _____ Phone _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Occupation _____ Hrs _____

Spouse: Place _____ Occupation _____ Hrs _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Contract/ID# _____ Contract/ID# _____

Group/Acct# _____ Group/Acct# _____

Subscriber _____ Subscriber _____

Subscriber Social Security # _____ Subscriber Social Security # _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Client's relationship to Subscriber _____ Client's relationship to Subscriber _____

__Self __Spouse __Son/Daughter __Self __Spouse __Son/Daughter

Referral Source

How did you hear of our clinic (or from whom)? _____

Address _____ City _____ State _____ Zip _____

Phone _____

If you need any more space for any of the questions please use the back of the sheet.

Do you (client) have a ___conservator ___guardian ___representative payee ___personal representative ___No ___Yes If Yes. Name _____ Phone _____ Address _____

Is someone coordinating your services (e.g. legal, mental health, physical)? ___No ___Yes If Yes. Name _____ Phone _____ Address _____

Primary reason(s) for seeking services

- ___ Anger management ___ Anxiety ___ Coping ___ Depression ___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns ___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs ___ Past Trauma ___ Other mental health or behavioral concerns (specify) _____

How old were you when you first felt these symptoms? _____

Any additional information that would assist us in understanding your concerns or problems _____

What are your goals for therapy (e.g., what outcome(s) would you like to take place?) _____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- ___ Aggression/Hostility ___ Verbal ___ Physical ___ Panic attacks ___ Emotional Outbursts ___ Alcohol dependence ___ Anger ___ Hallucinations ___ Anxiety ___ Avoiding people ___ Eating disorder ___ Homicidal Ideation ___ Chest pain ___ Speech problems ___ Computer addiction ___ Depression ___ Trembling ___ Other (specify) _____
- ___ Memory impairment ___ Higher than usual mood ___ Drug dependence ___ Racing Thoughts ___ Fatigue ___ Gambling ___ Sexual difficulties_ ___ Heart palpitations ___ High blood pressure ___ Low self esteem ___ Sleeping problems ___ Hopelessness ___ Judgment errors ___ Impulsivity ___ Irritability
- ___ Paranoid ___ Overly Sensitive ___ Phobias/fears ___ Rapid Speech ___ Recurring thoughts ___ Sexual addiction ___ Loneliness ___ Sick often ___ Worrying ___ Withdrawing ___ Distractibility ___ Social Difficulties ___ Disorientation ___ Suicidal thoughts ___ Thoughts disorganized

Describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) _____

What areas of your life are being affected by the above?

Social

- Unable to form or maintain friendships
- withdrawal from family and friends (excessive desire to be alone)
- increased conflict with others
- loss of interest in social activities
- phobias

Occupational

- unable to maintain job
- absenteeism
- conflicts with co-workers
- tardiness
- reduced productivity
- disciplinary action for poor performance

Academic

- failing grades
- truancy
- tardiness
- detention
- reduced productivity at school
- fighting/conflicts with students/teacher

Physical

- decreased energy/fatigue
- difficulty getting out of bed or insomnia
- decreased/increased appetite
- substantial weight loss or gain
- physical complaints (headaches, stomachaches, etc.)
- frequent illness

Affective Distress

- crying spells
- irritability
- anger/rage
- disorganized thoughts
- emotional meltdowns/breakdowns
- feeling overwhelmed with emotions
- worrying that interferes with the ability to concentrate
- memory problems
- concentration problems

Family Information

Your current relationship status:

- | | | |
|--|---|---|
| <input type="checkbox"/> Single | <input type="checkbox"/> Divorce in process | <input type="checkbox"/> Unmarried, living together |
| <input type="checkbox"/> Legally married | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Annulment | <input type="checkbox"/> Engaged |
| <input type="checkbox"/> Other _____ | | |

Assessment of relationship with significant other (if applicable) Good Fair Poor N/A

Would you like your family to be involved in your treatment? Yes No If yes, please describe the extent of involvement: _____

Name	Age	(Indicate if step or adopted)	Living?		Living with you?	
			Yes	No	Yes	No
Mother	_____	_____	____	____	____	____
Father	_____	_____	____	____	____	____
Spouse	_____	_____	____	____	____	____
Children	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____

Significant others in your life (brothers, sisters, grandparents, relatives, step-relatives)

Please specify relationship.

Relationship	Name	Age	Living?		Living with you?	
			Yes	No	Yes	No
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Parental Information (check those which apply)

Parents legally married Mother remarried Number of times _____

Parents have been separated Father remarried Number of times _____

Parents ever divorced (Your age at the time of divorce) _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.) _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If Yes, please describe _____

Has there been history of child abuse? Yes No

If Yes, which type(s)? Sexual Physical Verbal

Other childhood issues Neglect Inadequate nutrition Poor health

Other (please specify) _____

Comments regarding childhood development _____

Social Relationships

Check how you generally get along with other people (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Other (specify) _____

Do you currently have supportive friendships? Yes No

Sexual orientation _____ Comments _____

Sexual dysfunctions? Yes No

If Yes, describe _____

Any history or being abused by others? No Yes If Yes, what type(s) of abuse?

Emotional Sexual Physical Verbal Other describe _____

How old were you at the time of abuse?: _____

Any current behaviors or history as sexual perpetrator? Yes No

If Yes, describe _____

Do you have a history of social problems (e.g. bullying, bullying others) _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe _____

Other cultural/ethnic information _____

Spiritual/Religious

How important to you are spiritual matters to you? Not at all Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No If Yes, describe _____

Current Legal Status

Are you mandated for treatment? Yes No

Are you involved in any active cases (traffic, civil, criminal)? Yes No

If Yes, please describe and indicate the court and hearing/trial dates and charges _____

Are you presently on probation or parole? Yes No

If Yes, please describe _____

Past Legal History

Traffic violations Yes No

DWI, DUI, etc. Yes No

Criminal involvement Yes No

Civil involvement Yes No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply Currently enrolled in school Yes No

High school grad/GED Average school grades (current or previous) _____

Vocational Number of years Graduated Yes No Major _____

College Number of years Graduated Yes No Major _____

Graduate Number of years Graduated Yes No Major _____

Other training _____

Special circumstances (e.g., learning disabilities, gifted) _____

Employment

Begin with most recent job, list job history

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Work Status FT PT Temp Laid-off Disabled Retired

Social Security Student Other (describe) _____

Current Annual Income: \$ _____ **Personal** \$ _____ **Household**

Military

Military experience? Yes No Combat experience? Yes No

Branch _____ Discharge date _____

Type of discharge _____ Rank at discharge _____

Relative family member in the service? Yes No Who? _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health Condition (Check any problem areas you have or have had)

For each illness listed below, choose a single answer that best describes your health history:

Condition	Currently	In Past	Never	Condition	Currently	In Past	Never
Abortion				Loss of Consciousness			
Anemia				Memory Loss			
Appetite Change				Numbness			
Arthritis				Pain (Daily, Longer than 2 weeks)			
Asthma				Palpitations			
Back Pain				Paralysis			
Blood In Stool				Rheumatic Fever			
Blurred Vision				Seizures			
Caffeine Use				Shortness of Breath			
Chest Pain				Skin Disease			
Chicken Pox				Sleep Apnea			
Chronic Cough				Sleep Difficulties			
Colitis or Irritable Bowel				Stroke or TIA			
Confusion or Disorientation				Swallowing Difficulty			
Constipation				Dental Problems			
Diabetes				Thyroid Disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or Indigestion			
Emphysema				Urination Difficulty			
Fainting				Sexually Transmitted Disease			
Glaucoma				Weakness			
Head Injury				Recent Weight Gain			
Headaches (Frequent)				Recent Weight Loss			
Hearing Loss				Malnutrition			
Heart Disease				Epilepsy			
Miscarriage				HIV/AIDS			
Infertility				Hepatitis			
Low Libido				Energy Level			
Multiple Sclerosis				Other:			

List any current health concerns _____

List any recent health or physical changes _____

Please list all of your current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule?	What dose do you take, and how often?	Name of prescribing physician
Example: "Imakin"	Arthritis	Early 1998	1 table = 400 mg.	2 tablets, 3 times a day after meals	Dr. Smith

Please list all medications that you have taken in the past:

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Did the medicine cause any problems?
Example: "Imburstin"	High blood pressure	2 years	6 months ago	I lost weight and started exercising	dizziness

Describe your overall compliance with the above medications _____

Please list all nutritional and herbal supplements that you currently take: _____

Medication **Allergies:** _____

Have you ever had any bad reactions (made you feel worse) to prior medications (is so, specify): _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High
Comments	_____					

Physical Treatment

Primary physician _____

Phone _____

Hospital of choice _____

Phone _____

Address _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgeries	_____	_____	_____
	_____	_____	_____
Upcoming surgery	_____	_____	_____

Disabilities

Do you have any disabilities? No Yes If Yes, describe and note how it affects your physical and/or psychological functioning and how you adjust to your disability(ies) _____

Do you need assistive technology for the provision of services? Yes No Please describe:

Personal History of:	Currently	In the Past	Never
Substance Abuse			
Depression			
Anxiety			
Manic Depression (Bipolar)			
Suicide/Homicide Attempt			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

List family history of mental illness/substance abuse: Mother = mo father = fa sibling = s
 grandmother = gm grandfather = gf

Family History of:	Currently	In the Past	Never
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Suicide Attempt			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your ability to function or work ar at home? If yes, please provide details:

Chemical Use History – Have you Ever Used any of the following?

	Method of use and amount	Frequency of use	Age of first use	Age of last use
Alcohol	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Xanax, Klonopin, Ativan	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Substance(s) of preference

1. _____
2. _____
3. _____
4. _____

Describe when and where you typically uses substances _____

Describe any changes in your use patterns _____

Describe how your use has affected your family or friends (include their perceptions of your use)

Reason(s) for use

___ Addicted ___ Build confidence ___ Escape ___ Self-medication
___ Socialization ___ Taste ___ Other (specify) _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe _____

- ___ Has your use of alcohol or drugs interfered with your obligations at work?
- ___ Has your use of alcohol or drugs interfered with your obligations at school?
- ___ Has your use of alcohol or drugs interfered with your obligations at home?
- ___ Has your use of alcohol or drugs while driving a car or truck?
- ___ Have you used alcohol or drugs while operating machinery?
- ___ Have you ever been arrested as a result of drinking or using drugs?
- ___ Have you continued to use alcohol or drugs despite having problems caused by the effects of the alcohol or drugs?

- ___ Have you ever used more alcohol or used more drugs in order to achieve the desired effect?
- ___ Has there become a markedly diminished effect with the continued use of the same amount of the substance?
- ___ Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?
- ___ Have you ever used substances in larger amounts or over a longer period of time than was initially intended?
- ___ Have you attempted to cut down or control the amount of drinking or drug use without success?
- ___ Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?
- ___ Have important social, occupational, or recreational activities been given up or reduced because of the your use of alcohol or drugs?
- ___ Have you continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur?

Counseling/Prior Treatment History

Information about client (past and present)

	Yes	No	When	Where	Your reaction to the overall experience
Mental health counseling	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Mental Health Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Any immediate family in treatment currently? If yes, whom and where? _____

Previous mental health diagnosis(es) _____

Do you feel suicidal at this time? Yes No

If Yes, explain _____

Are you currently involved in any risk taking behaviors? No Yes Describe _____

Your Signature _____ Date _____

For Staff Use

Therapist's signature/credentials _____ Date /__/_

Supervisor's comments _____

_____ Physical exam: Required Not required

Supervisor's signature/credentials _____ Date __/__/__

(Certifies case assignment, level of care and need for exam)

Therapist's response to supervisor's remarks _____

Therapist's signature/credentials _____ Date __/__/__