# HOLOGRAPHIC MEMORY RESOLUTION®

## CLIENT STRESS/TRAUMA ASSESSMENT FORM

| Name: | Date of Birth: | | Age: | |
|---|---|---|---|---|
| Address: | | | | |
| City: | State: | | Zip: | |
| S.S.N.: | Marital Status: ☐(S) ☐(M) ☐(D) ☐(W) ☐(P) | | | |
| Home Phone: | Work Phone: | | | |
| Mobile Phone: | Other Phone: | | | |
| **Insurance Information:** | | | | |
| Source: ________ (Select Appropriate Number for Insurance Source)<br>1. Medicare, 2. Medicaid, 3. HMO, 4. PPO, 5. POS 6.Self-pay 7. Indemnity<br>8. Workman's Compensation, 9. Auto Insurance, 10. Other | | | | |
| Policy Holder's Name: | | | | |
| Primary Ins.: | | | | |
| Policy # : | Group #: | | | |
| Insurance Phone: | | | | |
| Secondary Ins.: | Subscriber: | | | |
| Pol./Member #: | Group #: | | | |
| Referring Physician: | | | | |
| Physician's Phone: | | | | |
| Primary Care Physician: | | | | |
| Primary's Care Physician's Phone: | | | | |
| Occupation: | Employer: | | | |
| Emergency Contact: | Relationship: | | | |
| Emergency Phone: | | | | |
| **Workman's Compensation Information:** | | | | |
| Claim File No.: | Date of the Accident: | | | |
| Workman's Compensation Contact Person: | | | | |
| Workman's Compensation Phone: | | | | |
| Workman's Compensation Carrier Information: | | | | |

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Authorization: I hereby authorize ______________________________________________ to furnish information to insurance carriers concerning this illness/accident. I acknowledge and understand that I am responsible for all charges at the time services are rendered for in office sessions and must prepay for phone appointments if requested. I understand I am financially responsible for all charges whether or not covered by insurance. I understand this office requires that cancellations for scheduled appointments to be received 24 business hours prior to the scheduled appointment time. The 24 hour time limit is intended to allow our office staff time to schedule another patient into the time your cancellation is making in the therapist's schedule. I understand that canceled appointments that do not follow this policy will be charged for the full appointment fee at the discretion of your therapist.

I understand that unpaid charges over 30 days old are subject to a 1.5% monthly finance fee. I further understand that I am solely responsible for this finance charge and my insurance company will not pay for either this fee or any un-kept appointment charges on my account.

Signature: ____________________________________ Date:

## PERSONAL HISTORY:

Case Number:

Client's Name: ________________________________________ Date:

Gender: M ☐ F ☐ Date of Birth: ____________________ Age:

Form Completed by: (Someone other than client)

### PRIMARY REASON(S) FOR SEEKING SERVICES

☐ Anger Management ☐ Eating Disorder ☐ Addictive Behaviors ☐ Alcohol/Drugs

☐ Coping ☐ Anxiety ☐ Depression ☐ Fear/Phobias

☐ Mental Confusion ☐ Migraines ☐ Post Traumatic Stress Disorder ☐ Trauma

☐ Chronic Pain ☐ Grief Issues ☐ Autoimmune Disorder - Please Specify type: ☐ Lupus, ☐ Fibromyalgia, ☐ Chronic Fatigue, ☐ Crohn's ☐ Arthritis ☐ Irritable Bowel Syndrome ☐ Colitis ☐ Colitis ☐ Psoriasis ☐ Other:

☐ Sexual Abuse ☐ Physical Abuse

☐ Emotional Abuse ☐ Marital Problems

☐ ACOA Issues ☐ Health Problems

☐ Other Mental Health Concerns: ______________________________________________

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**FAMILY INFORMATION:**

| RELATIONSHIP: | NAME: | AGE | HEALTHY YES | HEALTHY NO | AGE AT DEATH | LIVING W/ YOU YES | LIVING W/ YOU NO |
|---|---|---|---|---|---|---|---|
| Mother | | | ☐ | ☐ | | ☐ | ☐ |
| Father | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |
| | | | ☐ | ☐ | | ☐ | ☐ |

## RELATIONSHIP STATUS

☐ Single ☐ Married ☐ Separated ☐ Divorce in Process ☐ Divorced ☐ Living Together

☐ Partnership ☐ Widowed _____ Total Marriages

Current Relationship Assessment: ☐ Good ☐ Fair ☐ Poor ☐ Changing

Parental Relationship Status:

☐ Parents legally married: ☐ Living ☐ Deceased ☐ Parents separated

☐ Mother remarried: ____ Number of times ☐ Parents divorced: at your age ____

☐ Father remarried: ____ Number of times

Special Circumstances: (e.g. raised by person/s other than parents//children not living with you, etc.)

______________________________________________________________________________

______________________________________________________________________________

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## DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development: ☐ NO ☐ YES

If Yes, which type(s) of child abuse? ☐ Sexual ☐ Physical ☐ Verbal.

The abuse was experienced as: ☐ victim ☐ perpetrator

Other childhood issues: ☐ Neglect ☐ Hunger ☐ Other: ________________________________________

Comments re: childhood development/domestic violence/abuse: ______________________________________________

## SOCIAL RELATIONSHIPS

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

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue often ☐ Follower

☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/withdrawn ☐ Submissive

Other (specify): ____________________________________________________________________________

## CULTURAL/ETHNIC

From which cultural or ethnic group, if any, do you belong? ________________________________________________

Where do you come from geographically? ______________________________________________________________

Are you experiencing any problems due to cultural or ethnic issues? ☐ NO ☐ YES (describe) ________________

Other cultural/ethnic information: ________________________________________________________________

## SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ☐ Little ☐ Moderate ☐ Very Important

Are you affiliated with a spiritual or religious group? ☐ No ☐ Yes (describe) _____________________________

Were you raised within a spiritual or religious group? ☐ No ☐ Yes (describe) _______________________________

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐ No ☐ Yes (elaborate) ________

Was there "religious addiction" or excessive religious rigidity in your upbringing? ☐ No ☐Yes (describe) _________

______________________________________________________________________________________________

## LEGAL

**Current Status:**

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

If "Yes," please describe and indicate the court and hearing/trial dates and charges: ______________________________

Are you presently on probation or parole? ☐ No ☐ Yes. If yes, please describe: ___________________________

______________________________________________________________________________________________

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**Past History:**

Traffic Violations: ☐ No ☐ Yes Driving While Intoxicated (DWI/DUI): ☐ No ☐ Yes

Criminal Involvement : ☐ No ☐ Yes Civil Involvement: ☐ No ☐ Yes

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

| Charges: | Date: | Location (City): | Results: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## EDUCATIONAL

Fill in all that apply: Years of education: ________ Currently in school: ☐ No ☐ Yes

☐ High School Grad/GED – Year: ________ ☐ Vocational – years in training: _____ in field (name): ________

☐ College - No. of years ___________ Graduated: ☐ Yes ☐ No Major field: ___________________

☐ Graduate School – No. of years ____ Completed: ☐ Yes ☐ No Field: ________________________

Degrees: Associates Degree, Baccalaureate, Masters Degree, Ph. D., Other: __________________________

Other Training: ______________________________________________________________________________

Special Circumstances (e.g. learning disabilities/dyslexia/gifted, etc.): ____________________________________________

## EMPLOYMENT

| Employer | Dates | Title | Reason left job | How often miss work? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Laid-off ☐ Disabled ☐ Retired ☐ Social Security ☐ Student ☐ Graduate Student

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## LEISURE/RECREATIONAL

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

| Activity: | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## MEDICAL/PHYSICAL HEALTH

Are you allergic to any medications or drugs? ☐ No ☐ Yes (describe) ____________________________

| Current/Prescribed Medications: | Dosage: | Dates: | Purpose: | Side-effects: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Over the counter meds: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## MILITARY

Military Experience? ☐ No ☐ Yes Combat experience? ☐ No ☐ Yes Where? ______________________

Branch: ____________________________________ Date enlisted: ____________________________

Discharge Date: ______________________________ Type of discharge: __________________

Rank at discharge: ____________________________ Diagnosis of PTSD? ☐ No ☐ Yes ☐ Unknown

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## MEDICAL CARE RECORD

| Service: | Name of Caregiver: | Date: | Reason/Focus: | Result: |
|---|---|---|---|---|
| Physical Exam: | | | | |
| Last Doctor's Visit: | | | | |
| Last Dental Exam: | | | | |
| Most Recent Surgery: | | | | |
| Other Surgery: | | | | |
| | | | | |
| Psychiatric Visit: | | | | |
| | | | | |
| | | | | |
| Other Service: | | | | |
| | | | | |
| | | | | |
| | | | | |

CURRENT HISTORY: Please check if there have been any recent changes in the following:

☐ Sleep patterns ☐ Eating patterns ☐ Behavior ☐ Energy Level

☐ Physical activity level ☐ General disposition ☐ Weight ☐ Nervousness/tension

Describe changes in areas which you checked above: ____________________________________________________________

## NUTRITION

| Meal | How Often ( x per week) | Typical Foods Eaten | Typical Amounts Eaten |
|---|---|---|---|
| Breakfast | | | ☐ Low ☐ Med ☐ High |
| Lunch | | | ☐ Low ☐ Med ☐ High |
| Dinner | | | ☐ Low ☐ Med ☐ High |
| Snacks | | | ☐ Low ☐ Med ☐ High |

Have you been preoccupied with weight gain/ loss? ☐ No ☐ Yes (Explain)

Have you struggled with an eating disorder in the past? ☐ No ☐ Yes (Elaboration) ________________________________

______________________________________________________________________________________________

Did you receive inpatient or outpatient treatment for the eating disorder? ☐ No ☐ Yes (Where) ______________________

______________________________________________________________________________________________

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## PAIN ASSESSMENT

Please indicate by **number or appropriate letter** where you have experienced pain **over the last three months**, using the pain scale listed below. You may also indicate degrees of pain by using the appropriate letter: **"A" = Aching pain** **"N" = Numbness.** **"S" = Stabbing pain.** **"B" = Burning pain.** **"P" = Pins & Needles.**

| | Upper | Middle | Lower | Left | Right | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Abdomen | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Ankle | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Arm | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Back | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Bladder | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Breast/Pectoral | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Chest | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Collar bone | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Ear | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Elbow | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Esophagus | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Eye | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Fingers | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Foot | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Forearm | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Forehead | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Genital | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Gluteus | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Gut | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Hand | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Head | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Hip | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Jaw | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Kidney | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Knee | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Leg | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Liver | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Lung | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Mouth | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Neck | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Nose | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Ovary | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Pelvis | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Prostate | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Rotator Cuff | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Scapula | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Shoulder | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Sinus | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Skull-base | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Stomach | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Tailbone | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Teeth | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Thigh | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Throat | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Tricep | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Toes | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Wrist | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |
| Other: | ☐ | ☐ | ☐ | ☐ | ☐ | | | | | | | | | | | |

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Please check the following that apply to your pain:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | Throbbing | ☐ | Constant | ☐ | Gnawing | ☐ | Brief/ Momentary | ☐ | Fearful |
| ☐ | Shooting | ☐ | Steady | ☐ | Burning | ☐ | Transient | ☐ | Tiring-Exhausting |
| ☐ | Stabbing/Sharp | ☐ | Intermittent | ☐ | Aching | ☐ | Splitting | ☐ | Sickening |
| ☐ | Cramping | ☐ | Rhythmic | ☐ | Heavy | ☐ | Pulsing | ☐ | Punishing-Cruel |

Please mark all of the following specialists you have consulted for the pain:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Acupuncturist/ Allergist | ☐ | General Physician | ☐ | Internist /Osteopath |
| ☐ | Pain Clinic/ Hypnotist | ☐ | Neurologist | ☐ | Surgeon |
| ☐ | Psychiatrist/ Psychologist | ☐ | Neurosurgeon | ☐ | Podiatrist |
| ☐ | Chiropractor | ☐ | Physical Therapist | ☐ | Psychotherapist/other |

## MEDICAL HISTORY OF SYMPTOMS

**(Mark all appropriate)** **"C"** - Currently **"6"** -Within the last 6 months **"P"** -In the past **"N"**- Never

### General Health:

| | | | | | |
|---|---|---|---|---|---|
| | Insomnia | | Addiction | | Night Sweats/Bruise easily |
| | Fevers / Chills | | Fatigue / Weakness | | Dizziness / Tremors |
| | Alcohol Use (How much) | | Diabetes | | Stroke |
| | Weight Loss (How much) | | Weight Gain – lbs: | | Weight a year ago: |
| | Cancer (type) | | Pregnant? | | Recreational drug use |
| | Last "period" - date | | Due date: | | IV drug use |

### Immunological/Hemotologic

| | | | | | |
|---|---|---|---|---|---|
| | Autoimmune disease | | Fibromyalgia | | Raynauds/Lupus/M.S. |
| | Anemia/Blood disorder | | Celiac/Gluten intoler. | | HIV/AIDS |

### Head, Eyes, Ears, Nose & Throat

| | | | | | |
|---|---|---|---|---|---|
| | Ringing in ears | | Sinus problems | | Sores in mouth |
| | Hearing problems | | Nose bleeds | | Head injury / Stroke |
| | Headaches | | Recurrent sore throat | | Other |

### Cardiovascular

| | | | | | |
|---|---|---|---|---|---|
| | Chest pain | | Irregular heart/Pacemaker | | Fainting |
| | Poor circulation | | Swelling in feet | | Hypertension |
| | Myocardial infarction | | Mitral Valve Prlpse/Murmur | | Valve replacement |

### Musculoskeletal

| | | | | | |
|---|---|---|---|---|---|
| | Neck pain | | Back pain | | Tennis elbow |
| | Joint pain | | Muscle spasm | | Carpal Tunnel Syndrome |
| | Osteoarthritis | | Rheumatoid arthritis | | Bursitis |
| | Joint injury | | Other | | |

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**"C"** - Currently **"6"** -Within the last 6 months **"P"** -In the past **"N"**- Never

**Respiratory**

| | | | | | |
|---|---|---|---|---|---|
| | Wheezing / Asthma | | Short of breath | | Pneumonia / Bronchitis |
| | Emphysema / COPD | | Tuberculosis | | Cough |
| | Smoking - Packs/day:<br>Quit When: | | Home oxygen | | Cancer |

**Skin & Hair**

| | | | | | |
|---|---|---|---|---|---|
| | Hives / Rashes / Itching | | Skin changes / Hair loss | | Ulcerations |

**Gastrointestinal/genitourinary**

| | | | | | |
|---|---|---|---|---|---|
| | Nausea / Vomiting | | Abdominal cramps | | Acid reflux / Indigestion |
| | Diarrhea | | Constipation | | Food allergies (submit list) |
| | Last period: | | Yeast infections / STD's | | Irritable Bowel Syndrome |
| | Frequency/urgency | | Burning on urination | | Birth control |
| | Prostate pain | | Prostate enlargement | | Urinary tract issue |

**Renal/ Hepatic**

| | | | | | |
|---|---|---|---|---|---|
| | Dialysis/Kidney probl. | | Kidney/Bladder infection | | Hepatitis / Liver problems |

**Neuropsychological**

| | | | | | |
|---|---|---|---|---|---|
| | Depression | | Stroke | | Seizure disorder |
| | Stress problems | | Poor memory | | Other |
| | Anxiety | | Black out spells | | Addiction |

**Sexual Function** ☐ I prefer not to answer these questions.

| | | | | | |
|---|---|---|---|---|---|
| | Sexually active | | Infertility issues | | PMS symptoms |
| | Satisfied sex life | | Difficulty with climax | | How many partners? |

**Diet/Activity**

| | | | | | |
|---|---|---|---|---|---|
| | Poor food choices | | Lack of regular exercise | | Irregular eating habits |
| | Weight Problem | | Desire to exercise regularly | | Desire better eating habits? |

**Family History:** M=mother, F=father, C=child, GP=grandparent, S=sibling

| | | | | | |
|---|---|---|---|---|---|
| | Heart disease | | High Blood Pressure | | Stroke |
| | Lung disease | | Kidney disease | | Glaucoma |
| | Autoimmune disease | | Obesity/Eating Disorder | | Psychiatric disease |
| | Depression | | Cancer (type): | | Alcoholism/Addiction |

**Sleep Patterns:** Please mark the statement that best describes your sleep pattern:

☐ I sleep well, ☐ Pain occasionally interrupts my sleep, ☐ Pain interrupts my sleep half of the time,
☐ Pain often interrupts my sleep, ☐ Pain always interrupts my sleep, ☐ I never sleep well.
Have you ever been diagnosed with a sleep disorder? ☐ No ☐ Yes (describe) ______________________

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## CHEMICAL USE HISTORY

| Substance: | Method of Use & Amount | Frequency | Age of First Use | Age of Last Use | Used in Last 48 Hours: "YES" | Used in Last 48 Hours: "NO" | Used in Last 30 Days: "YES " | Used in Last 30 Days: "NO" |
|---|---|---|---|---|---|---|---|---|
| Alcohol | | | | | ☐ | ☐ | ☐ | ☐ |
| Barbiturates | | | | | ☐ | ☐ | ☐ | ☐ |
| Benzodiazepines: Xanax, Klonopin, Valium, Ativan | | | | | ☐ | ☐ | ☐ | ☐ |
| Cocaine/Crack | | | | | ☐ | ☐ | ☐ | ☐ |
| XTC/Ecstasy | | | | | ☐ | ☐ | ☐ | ☐ |
| Inhalants | | | | | ☐ | ☐ | ☐ | ☐ |
| Heroin/Morphine/Opiates | | | | | ☐ | ☐ | ☐ | ☐ |
| Marijuana | | | | | ☐ | ☐ | ☐ | ☐ |
| PCP/LSD/Mescaline | | | | | ☐ | ☐ | ☐ | ☐ |
| Caffeine | | | | | ☐ | ☐ | ☐ | ☐ |
| Nicotine | | | | | ☐ | ☐ | ☐ | ☐ |
| Over the counter meds: | | | | | ☐ | ☐ | ☐ | ☐ |
| Prescription meds: | | | | | ☐ | ☐ | ☐ | ☐ |
| Other drugs: | | | | | ☐ | ☐ | ☐ | ☐ |

**Substance Abuse Questions:**

Describe when and where you typically use substances: ______________________________

Describe any changes in your patterns: ______________________________

Describe how your use has affected your family or friends (include their observations): ______________

**Reasons for Use:** ☐ **Addicted** ☐ **Build confidence** ☐ **Escape** ☐ **Self-medication**

☐ **Social Anxiety** ☐ **Taste** ☐ **Boredom** ☐ **Other:**

**When using a stimulant, do you "speed up" or "slow down/get sleepy"?** ______________________

**Have you ever been diagnosed with ADD or Bipolar Disorder?** ☐ **No** ☐ **Yes**

**How do you believe your substance use affects your life?** ______________________________

**Who or what has helped in stopping/limiting your use?** ______________________________

**Does/has someone in your family (present/past) have (had) a problem with drugs or alcohol?** ☐ **No** ☐ **Yes**

**Describe the circumstances:** ______________________________

**Have you had withdrawal symptoms when trying to stop drugs/alcohol?** ☐ **No** ☐ **Yes** **Describe your experience:**

______________________________________________________________

**Have you had adverse reactions or overdose to drugs & alcohol? (Describe)** ______________________

**Have drugs or alcohol created a problem for your job?** ☐ **No** ☐ **Yes (Describe)** ______________

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# COUNSELING/PRIOR TREATMENT HISTORY

## Client Therapy History:

| EXPERIENCE | NO | YES | WHEN | PURPOSE | LOCATION | OUTCOME |
|---|---|---|---|---|---|---|
| Counseling | ☐ | ☐ | | | | |
| Psychiatric Treatment | ☐ | ☐ | | | | |
| Drug/Alcohol Tx. | ☐ | ☐ | | | | |
| Hospitalizations | ☐ | ☐ | | | | |
| 12 Step Groups | ☐ | ☐ | | | | |
| Other self-help | ☐ | ☐ | | | | |

Have you had any suicidal thoughts or attempts in your past? Describe: ________________________________________

### Family/Significant Others History:

| EXPERIENCE | RELATION | WHEN | PURPOSE | LOCATION | OUTCOME |
|---|---|---|---|---|---|
| Counseling | | | | | |
| Psychiatric Treatment | | | | | |
| Drug/Alcohol Tx. | | | | | |
| Hospitalizations | | | | | |
| 12 Step Groups | | | | | |
| Other self-help | | | | | |

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

| | | | |
|---|---|---|---|
| ☐ Aggression | ☐ Dizziness | ☐ Irritability | ☐ Sleeping problems |
| ☐ Alcohol Dependence | ☐ Drug dependence | ☐ Judgment errors | ☐ Speech problems |
| ☐ Anger | ☐ Eating disorder | ☐ Loneliness | ☐ Suicidal thoughts |
| ☐ Antisocial behavior | ☐ Elevated mood | ☐ Memory impairment | ☐ Thoughts disorganized |
| ☐ Anxiety | ☐ Fatigue | ☐ Mood shifts | ☐ Trembling |
| ☐ Avoiding people | ☐ Gambling | ☐ Obsessive thoughts | ☐ Withdrawing |
| ☐ Chest pain | ☐ Hallucinations | ☐ Panic attacks | ☐ Worrying |
| ☐ Cyber addiction | ☐ Heart palpitations | ☐ Phobias/fears | ☐ Other: |
| ☐ Depression | ☐ High blood pressure | ☐ Sexual addiction | |
| ☐ Disorientation | ☐ Hopelessness | ☐ Sexual difficulties | |
| ☐ Distractibility | ☐ Impulsivity | ☐ Sick frequently | |

**Briefly discuss how the above symptoms impair your ability to function effectively:** ___________________________

_______________________________________________________________________________________________

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## FOR STAFF USE ONLY

**Name of reviewing Staff Member: ______________________________________________ Date: _________**

**Therapist's Signature & Credentials: __________________________________________________**

**Supervisor/Director's Comments: _______________________________________________________**

________________________________________________________________________________________________

________________________________________________________________________________________________

**If Research consent is given:**

**Research Staff signature: ____________________________________________________ Date: __________**

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