Demographics & Life Status

Name: _____ Pronouns: _____

Phone:(_____)_____ Email: _____

Address: _____ City, State, Zip Code: _____

Age: _____ DOB: _____ /_____ /_____ Place of birth: _____

Sex: _____ (Assigned female at birth, assigned male at birth, intersex, etc.)

Gender: _____(Cisgender, Transgender, Non-binary, Gender diverse, etc.)

Race: _____ (ex. African American, Asian, Black, Caucasian, Hispanic, etc.)

Marital Status: Single __ Married __ Partnered __ Divorced __ Widowed __ Separated __ Other _____

If applicable, Partner/Spouse's name & age_____

If applicable, children's name & ages_____

Who do you live with?_____

Referral source: How did you find us?_____

Emergency Contact - Name: _____ Phone: (_____)_____

Cultural, religious, spiritual influences/considerations (community, arts, beliefs, celebrations, customs, traditions):

_____

Describe Current Economic/financial Situation: _____

Education & Employment History

Name of institution / Degree

Secondary _____

College _____

Graduate _____

Job or Volunteer Title/Description: (From when to when, full/part-time)

_____

_____

Significant Personal Relationships/Family

Describe significant relationships, supportive or not (immediate & extended family, friends, partners, etc.):

_____

_____

_____

Name(s)/ Age/ Living: Yes / No

Father: _____

Mother: _____

Siblings: _____

Others: _____

Strengths, Activities, Resources & Support Systems

List some of your strengths: _____

_____

Activities/Hobbies: _____

_____

# of hours/week engaged in leisure activities outside of the home: _____

What helps you get through each day? What resources do you have in your life? _____

_____

_____

Mental & Physical Health Status - Any current psychiatric diagnosis: _____

_____

Any problems or other conditions you have concerns about? _____

_____

How do these things affect your current daily functioning? _____

_____

Symptom Checklist - Use checkmark - **_ for CURRENT symptoms** & an asterisk - **✱ for PAST symptoms:**

- ❑ Anxiety
- ❑ Panic Attack
- ❑ Depressed Mood
- ❑ Decreased Concentration
- ❑ Decreased Energy
- ❑ Executive Dysfunction
- ❑ Irritability
- ❑ Hyperactivity
- ❑ Hopelessness
- ❑ Tearfulness
- ❑ Guilt
- ❑ Grief
- ❑ Somatic issues
- ❑ Flashbacks/Night Terrors
- ❑ Dissociation
- ❑ Memory Problems
- ❑ Mood Swings/Lability
- ❑ Mania/Hypomania
- ❑ Insomnia/Hypersomnia
- ❑ Impulsivity
- ❑ Obsessions/Compulsions
- ❑ Intrusive/Ruminating Thoughts
- ❑ Paranoia
- ❑ Delusions
- ❑ Hallucinations
- ❑ Phobia(s)
- ❑ Other symptoms not listed:

What are your goals & needs when it comes to mental health support? _____

_____

_____

_____

List current providers / treatment (primary care doctor, nurse, psychiatrist, therapist, social worker, ARMHS, PCA, other):

_____

_____

_____

Current medications: _____

_____

Provider of medications: _____

List past therapeutic, psychiatric, & psychiatric hospitalization treatment, including names of providers & dates:

_____

_____

_____

Describe current or past physical, emotional, or sexual abuse experienced and/or witnessed :

_____

_____

_____

_____

_____

For Mental Health Professional only: If necessary, reports made to Adult or Child Protection: □

Other significant issues, stressors, or milestones in infancy or childhood: _____

_____

_____

_____

Other significant issues, stressors, or milestones in adulthood: _____

_____

_____

_____

Significant Deaths & dates (including pets): _____

Legal issues:: _____

Self esteem issues: _____

_____

Social concerns: _____

_____

Have you had suicidal thoughts or attempts? If so, please describe: _____

_____

_____

_____

For Mental Health Professional only:
Current Suicide Risk Assessment: □ low □ moderate □ high - If necessary, Referrals Made or APS contacted: □

Describe any family mental health issues and Family Substance abuse. Include history: _____

_____

_____

_____

_____

Chemical Use/Dependency - How often do you use alcohol, drugs, or cigarettes? _____

_____

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐yes ☐no
2. Have people annoyed you by criticizing your drinking or drug use? ☐yes ☐no
3. Have you ever felt bad or guilty about your drinking or drug use? ☐yes ☐no
4. Have you ever had a drink/used drugs first thing in the morning to steady nerves or to get rid of a hangover? ☐yes ☐no

Previous chemical dependency treatment (where, when):

_____

_____

_____

List current medical problems and treatments: _____

_____

_____

_____

Previous medical problems, childhood included: _____

_____

_____

_____

List family medical history/issues: _____

_____

_____

Signature **Date**

_____

For Mental Health Professional only:

*Releases obtained & sent for Current/Past assessments & treatment plans □

WHODAS given at DA session □

Completed other Assessment tools (As need be):

Beck Depression □ Beck Anxiety □ Further CD Assessment □ Other □_____

Reviewed previously administered psychological assessments as listed with results and dates noted:

_____

Mental Health Practitioner who reviewed this form, **Print, Sign, & Date**

_____

Licensed Mental Health Professional, (if different than above) **Print, Sign, & Date**

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