

INITIAL CLIENT SELF-REPORT

Thank you so much for looking to our practice for your counseling needs. I'm sure we will be able to provide the support you are seeking. Please take a few moments to fill out this form. Take your time and be as candid as possible.

CLIENT NAME

DATE COMPLETED

DATE OF BIRTH

SOCIAL SECURITY #

NAME OF PERSON COMPLETING THIS FORM IF OTHER THAN CLIENT.

*(**If Minor, Legal Guardian must complete this form and sign and date at end of form).*

DEMO & INITIAL INFO

EMPLOYER

OCCUPATION

REFERRAL SOURCE

HOW DID YOU HEAR ABOUT US ?

WHY ARE YOU SEEKING COUNSELING AND WHY NOW ?

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH COUNSELING ?

PLEASE LIST YOUR CURRENT FAMILY AND CLOSEST FRIENDS WHO ARE YOUR GREATEST SOURCES OF SUPPORT.

HAVE YOU HAD ANY RECENT / INTENSE LOSSES IN PAST 18 MONTHS ?
(DEATHS, LAYOFFS, DIVORCE, TRAGEDY, ETC)

SCHOOL/LEARNING OR BEHAVIORAL PROBLEMS AS A CHILD OR TEENAGER ?

LEGAL PROBLEMS (indicate past / present)

MEDICAL / EMOTIONAL HEALTH TREATMENT

PREVIOUS TREATMENT – **MEDICAL** / DATES
(indicate dates, condition, level of care, provider name)

PREVIOUS TREATMENT – **MENTAL HEALTH & SUBSTANCE ABUSE** / DATES
(indicate dates, condition, level of care, provider name)

SUBSTANCE ABUSE HISTORY

YES (if Yes, continue with below)

NO (if No, skip to Family History of SA/Dep)

SUBSTANCE ABUSE HISTORY IN PAST & WITHIN PAST 12 MONTHS
(substance / amount / freq / age began / last use)

FAMILY HISTORY OF SUBSTANCE ABUSE / DEPENDENCE
(family member, substances, amount, frequency, still using today?)

SUBSTANCE ABUSE / DEPENDENCE

LONGEST PERIOD OF SOBRIETY?

WHAT SYMPTOMS DO YOU EXPERIENCE WHEN IN WITHDRAWAL ?
(TREMBLING, AGITATION, NAUSEA, SLEEP PROBLEMS)

- SUPPORT SYSTEM / PEERS CONCERNED ABOUT YOUR USE?
- USE TO RELIEVE UNPLEASANT FEELINGS OR STRESS?
- PREOCCUPATION WITH ALCOHOL AND DRUGS USE?
- EXPERIENCED PHYSICAL DISCOMFORT AFTER USE OR A DAY AFTER USE?
- INCREASED TOLERANCE OF ALCOHOL AND/OR DRUG OF CHOICE?
- CONTINUED USE DESPITE NEGATIVE LIFE / WORK IMPACT?
- EVIDENCED MEDICAL/PHYSICAL SYMPTOMS RELATED TO USE?
- MINIMIZATION/INCONSISTENCY IN REPORTING USE PATTERNS/HISTORY?

PREVIOUS COUNSELING / TREATMENT

WHAT KIND OF COUNSELING SERVICES HAVE YOU HAD IN THE PAST AND WHAT ABOUT IT DID YOU FIND HELPFUL ? WHAT ABOUT YOUR PREVIOUS COUNSELING EXPERIENCES WERE NOT HELPFUL ?

PROBLEMS AT WORK

- | | |
|--|--|
| ABSENTEEISM <input type="checkbox"/> | TARDINESS <input type="checkbox"/> |
| SAFETY ISSUES / ACCIDENT <input type="checkbox"/> | POSITIVE UDS <input type="checkbox"/> |
| PRODUCTIVITY ISSUES <input type="checkbox"/> | CONFLICT AT WORK <input type="checkbox"/> |
| CUSTOMER COMPLAINT <input type="checkbox"/> | TRANSFERS / DEMOTIONS <input type="checkbox"/> |
| POLICY VIOLATIONS (HARRASMENT, VIOLENCE, ETC) <input type="checkbox"/> | ANGER MANAGEMENT <input type="checkbox"/> |

DETAILS OF WORK-RELATED PROBLEMS:

SCHOOL PROBLEMS

(if minor or if in college/tech/trade)

NAME OF SCHOOL:

SUSPENSION / PROBATIONARY STATUS?:

COUNSELOR / SCHOOL CONTACT

DETAIL OF SCHOOL-RELATED PROBLEMS:

IF CLIENT IS A MINOR

Legal Guardian's Name & Phone Number :

I do hereby swear and attest that I am the sole and/or primary legal guardian for the minor named as "client" on this form and further swear that I have completed this form in its entirety and have the full and complete legal authority to access counseling services for the client as I deem may be needed.

Printed Name: _____

Signature: _____

Date: _____