ASSESSMENT SELF REPORT INFORMATION

For parents please complete this form answering each question for your child.

First Name:	Last Name:

Goals:

Please let us know in detail what you need help with (issues you are experiencing):

Please check all that apply:

☐ Danger to Self	☐ Danger to Others	☐ Argumentative	☐ Violent
☐ Cutting Self	☐ Depressed	☐ Hallucinations	☐ Delusions
☐ Paranoia	☐ Agitation	☐ Anxiety	☐ Mania
☐ Mood Swings	☐ Isolation	☐ Obsessions	☐ Impulsive
☐ Other: ______			

Family History of Mental Health and Substance Abuse ☐ None/Denies

Who	Mental Health / Substance Abuse	Negative Impact for You
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No
	☐ Mental Health ☐ Substance Abuse	☐ Yes ☐ No

Your History of Mental Health Services ☐ None/Denies

Service Type (Crisis Unit, Outpatient, Residential, etc.)	Diagnosis or Issue	Dates of Service	Outcome of Service
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor

Your History of Substance Use ☐ None/Denies

Type of Substance	Age When First Used	Age When Last Used	Would you like to address in treatment?
☐ Alcohol (beer, wine, and liquor)			☐ Yes ☐ No
☐ Tobacco (cigarettes)			☐ Yes ☐ No
☐ Marijuana			☐ Yes ☐ No
☐ Synthetics (spice, bath salts, etc.)			☐ Yes ☐ No
☐ Inhalants (huffing)			☐ Yes ☐ No
☐ Hallucinogens (acid, mushrooms, etc.)			☐ Yes ☐ No
☐ Stimulants (caffeine, speed, meth, etc.)			☐ Yes ☐ No
☐ Sedatives (xanax, valium, etc.)			☐ Yes ☐ No
☐ Opiates (heroine, suboxone, methadone, roxy, etc.)			☐ Yes ☐ No
☐ Crack/Cocaine			☐ Yes ☐ No
☐ Tranquilizers (special k, etc.)			☐ Yes ☐ No
☐ Other:			☐ Yes ☐ No

Your History of Substance Use Services ☐ None/Denies

Service Type (Detox, Outpatient, Residential, etc.)	How Long in Treatment	Response to Treatment
		☐ Good ☐ Fair ☐ Poor
		☐ Good ☐ Fair ☐ Poor
		☐ Good ☐ Fair ☐ Poor

PATIENT

Name:

ID#:

Please check all that apply in each category:

Treatment Needs:
- ☐ Medication teaching
- ☐ Goal Setting
- ☐ Signs and symptoms of stress and anxiety
- ☐ Signs and symptoms of depression
- ☐ Substance use (alcohol and/or drugs)
- ☐ Mental health concerns
- ☐ Lifestyle changes
- ☐ Daily living skills
- ☐ Wellness
- ☐ Care of physical illnesses /conditions
- ☐ Dynamics of chemical abuse
- ☐ Relapse prevention
- ☐ Trauma treatment
- ☐ Coping skills
- ☐ Domestic violence treatment
- ☐ Grief counseling
- ☐ Safety planning
- ☐ Relationship building
- ☐ Other:

Community Needs:
- ☐ Referral to Medical Doctor
- ☐ Housing
- ☐ Legal Assistance
- ☐ Financial assistance with medications
- ☐ Advanced Directives
- ☐ HIV/AIDS Resources
- ☐ Transportation
- ☐ Employment
- ☐ Support groups
- ☐ Public Assistance
- ☐ Veteran resources
- ☐ Other:

Strengths:
- ☐ I adhere to my medication plan
- ☐ I manage my health care needs
- ☐ I live independently
- ☐ I have a positive support system
- ☐ I am communicative
- ☐ I am financially stable
- ☐ I have a good sense of humor
- ☐ I am motivated
- ☐ I am spiritual
- ☐ I exercise regularly
- ☐ I make good grades
- ☐ I am respectful
- ☐ Other:

Abilities/Interests:
- ☐ I am creative
- ☐ I am athletic
- ☐ I have a good sense of humor
- ☐ I advocate for myself
- ☐ I have good social skills
- ☐ I volunteer in my community
- ☐ I have good parenting skills
- ☐ I am able to manage time well
- ☐ I empathize
- ☐ I have a hobby
- ☐ I manage money well
- ☐ I am organized
- ☐ I participate in sports/clubs
- ☐ I enjoy reading
- ☐ I enjoy writing/drawing
- ☐ Other:

Preferences:
- ☐ Male Counselor
- ☐ Female Counselor
- ☐ Counselor not in recovery
- ☐ Counselor in recovery
- ☐ To live independently
- ☐ AM Appts
- ☐ PM Appts
- ☐ Not address substance use
- ☐ Not address mental health
- ☐ Not address physical concerns
- ☐ Medication management
- ☐ Individual therapy, not group
- ☐ Group therapy
- ☐ Community resources
- ☐ Religious/Spiritual considerations
- ☐ Auxiliary aids for hearing/seeing
- ☐ Family involved in treatment. If so, who? _______________________
- ☐ Other:

Do you have any Advanced Directives? ☐ Yes ☐ No
- ☐ Living Will
- ☐ Durable Power of Attorney
- ☐ Do Not Resituate
- ☐ Proxy
- ☐ Surrogate Medical
- ☐ Psychiatric

If you answered No, Do you want information about Advance Directives? ☐ Yes ☐ No

Is there anyone you would like for us to contact in the event you need a higher level of care? ☐ Yes ☐ No
If Yes, who? _______________________

If you need a higher level of care such as a crisis stabilization unit or hospital, do you have a preference of where you'd like to go? ☐ Yes ☐ No
If Yes, where? _______________________

Do you want information on Psychiatric Advanced Directives?
☐ Yes ☐ No

Patient/Guardian Signature: ____________________________________ Date: _________________

PATIENT

Name:

ID#: