

Date Completed: _____

Client ID# _____

INITIAL SERVICE CONSULTATION (ADULT)

BACKGROUND INFORMATION

First and Last Name: _____

Maiden Name (if applicable): _____

DOB: _____ Sex: Male Female Other

Race: _____ Hispanic/Latino: YES NO

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

E-mail: _____

Marital Status: Single Married Separated Divorced Widowed

Military Status: None Active Duty Military Dependent

Veteran - honorable discharge Veteran - dishonorable discharge

EMERGENCY CONTACT

First and Last Name: _____

Phone: _____ Relation: _____

PRESENTING PROBLEM

Please write a couple of sentences concerning the reason for your request of services.

When did these problems start? _____

How intense are these problems? _____

How often are they a problem? _____

Has there been changes or difficulties in: Mood Sleep Appetite Concentration Substance Use

Anger/Aggression Social withdrawal Anxiety

What other stressors are present? (e.g., poverty, court proceedings, DHS involvement, legal involvement, safety concerns)

CURRENT LIVING SITUATION

I live (check one): w/Family Alone w/Significant Other Other: _____

CHILDREN LIVING IN THE HOME (If applicable.)

Name: _____ DOB: _____ M F Other

Name: _____ DOB: _____ M F Other

Name: _____ DOB: _____ M F Other

Name: _____ DOB: _____ M F Other

OTHER ADULTS LIVING IN THE HOME (If applicable.)

Name: _____ DOB: _____ M F Other

Relationship to Client: _____

Name: _____ DOB: _____ M F Other

Relationship to Client: _____

EDUCATION/EMPLOYMENT

What is your highest level of education?: _____

Were you ever diagnosed with an intellectual, development, learning or other disability? YES NO

>If yes, please indicate diagnosis: _____

Did you ever receive special education services? YES NO

>If yes, please indicate age and type: _____

What is your employment status: Full-time Part-Time Unemployed Retired

Do you receive SSI? YES NO Do you receive SSDI? YES NO

What is your annual income (required for those using Soonercare): _____

Please share any educational or employment related needs that you would like assistance with: NONE

PHYSICAL/MENTAL HEALTH

Please list all current medications taken for physical or mental health: **If none, check here:**

Medication	Strength & Dose	Duration	Reason

Mental Health

Please indicate any biological family history of mental health issues: **If none, check here:**

- Post-Traumatic Stress Disorder (PTSD) – If yes, whom: _____
- Personality Disorder – If yes, whom: _____
- Schizophrenia – If yes, whom: _____
- Hallucinations (visual or auditory) – If yes, whom: _____
- Substance Abuse – If yes, whom: _____
- Addiction – If yes, whom: _____
- Depression Postpartum Depression – If yes, whom: _____
- Anxiety – If yes, whom: _____
- ADD/ADHD – If yes, whom: _____
- Bipolar Disorder – If yes, whom: _____
- Violence – If yes, whom: _____
- Other: _____

Are you currently or have you ever experienced hallucinations (auditory or visual)? YES NO

Have you ever been diagnosed with a mental illness? YES NO

>If yes, please list: _____

>If yes, by whom: _____

Are you currently receiving behavioral/mental health services elsewhere? YES NO

>If yes, please indicate:

Provider: _____ Reason: _____

Have you received behavioral/mental health services in the past? YES NO

>If yes, indicate:

When: _____ Provider: _____

Reason: _____ Reason Ended: _____

Physical Health

Are you currently under the care of a physician for medical problems/chronic illness? YES NO

>If yes, describe: _____

Do you currently smoke cigarettes or use other tobacco products? YES NO

>If yes, please describe amount, frequency, and type:

>If yes, would you like treatment to reduce or eliminate your use of tobacco products? YES NO

Do you drink alcohol? YES NO

>If yes, please describe amount, frequency, and type:

>If yes, would you like treatment to reduce or eliminate your use of alcohol? YES NO

Are you currently using other substances? YES NO

>If yes, please describe amount, frequency, and type:

>If yes, would you like treatment to reduce or eliminate your use of other substances? YES NO

Have you ever been treated for an addiction or substance abuse? YES NO

>If yes, please indicate type: _____

>If yes, what is current recovery status and sober living activities? _____

TRAUMA/ADVERSE CHILDHOOD EXPERIENCES (ACES)

While you were growing up, during your first 18 years of life:

YES NO Did a parent or other adult in the household often:
Swear at you, insult you, put you down or humiliate you?
OR
Act in a way that made you afraid that you might be physically hurt?

YES NO Did a parent or other adult in the household often:
Push, grab, slap, or throw something at you?
OR
Ever hit you so hard that you had marks or were injured?

YES NO Did an adult or person at least 5 years older than you ever:
Touch or fondle you or have you touch their body in a sexual way?
OR
Try to actually have oral, anal, or vaginal sex with you?

YES NO Did you *often* feel:
No one in your family loved you or thought you were important or special?
OR
Your family didn't look out for each other, feel close to each other, or support each other?

YES NO Did you *often* feel that:
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
OR
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

YES NO Were your parents ever separated or divorced?

YES NO Was your parent...
Often pushed, grabbed, slapped, or had something thrown at him/her?
OR
Sometimes or often kicked, bitten, hit with a fist or with something hard?
OR
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

YES NO Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

YES NO Was a household member depressed or mentally ill or did a household member attempt suicide?

YES NO Did a household member go to prison?

Please indicate current or past experiences with the following during adulthood:

	In the past	Currently	No
Physical Abuse/Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
>If yes, when and by whom? _____			

	In the past	Currently	No
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
>If yes, when and by whom? _____			

	In the past	Currently	No
Emotional/Mental Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
>If yes, when and by whom? _____			

Please share any other traumatic incidents you have experienced:

RISK FACTORS

Self-Harm

Have you ever had thoughts of self-harm (e.x. cutting, burning)? YES NO

>If yes, identify month & year of most recent thought(s): _____

Have you ever engaged in self-harm? YES NO

>If yes, identify month & year of most recent act(s): _____

Suicide

Have you ever had thoughts of suicide? YES NO

>If yes, identify month & year of most recent thought(s): _____

Have you ever attempted suicide? YES NO

>If yes, identify month & year of attempt(s): _____

Homicide

Have you ever had thoughts of homicide? YES NO

>If yes, identify month & year of most recent thought(s) and toward whom: _____

Have you ever attempted homicide? YES NO

If yes, identify month & year of attempt(s): _____

Violence

Have you ever been charged with a violent crime? YES NO

If yes, please describe: _____

Have you ever had a VPO filed against you? YES NO

If yes, please describe: _____

STRENGTHS & SUPPORTS

What are your hobbies? _____

How would you describe your social relationships?

Describe your support system:

Describe your faith or spirituality:

Is there any other information you feel is important for us to know?
