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.
NOTE: At this time, we only provide counseling services for grief related problems stemming from a death, anticipated death, pregnancy loss, and infertility.

_____

_____

_____

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? (poverty, court proceedings, DHS involvement, legal involvement, etc.)

_____

_____

Reminder…

Treatment Providers CANNOT:

- Go to court
- Provide opinions or recommendations to the court, GAL, DHS, or other entity
- Be investigative

Treatment Providers CAN:

- Communicate facts only to attorneys, GAL's or other entities ONLY WHEN an authorization to release confidential information is signed.

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

_____

_____

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_____

_____

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 – 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?

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☐ YES ☐ NO Did an adult or person at least 5 years older that 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 <u>during adulthood</u>:

	In the past	Currently	No
Physical Abuse/Violence	☐	☐	☐

>If yes, when and by whom? _____

_____

	In the past	Currently	No
Sexual Abuse	☐	☐	☐

>If yes, when and by whom? _____

_____

	In the past	Currently	No
Emotional/Mental Abuse	☐	☐	☐

>If yes, when and by whom? _____

_____

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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?

_____

_____

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_____

_____

Describe your support system:

_____

_____

_____

_____

Describe your faith or spirituality:

_____

_____

_____

_____

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

_____

_____

_____

_____