

ACTIVITIES OF DAILY LIVING

Please check areas that give you difficulty or require assistance from another person.

- grooming/hygiene shopping mobility leisure skills homemaking
 - time management bathing child care banking communication
 - stress management cooking budgeting dressing transportation
 - other _____ Describe recent difficulties _____
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MENTAL HEALTH

Have you had mental health services, counseling or alcohol/drug treatment? yes no

If yes, please list names and dates below.

Outpatient therapist or program & date(s) _____

Inpatient hospital & date(s) _____

Regarding past treatment, what did you find most helpful, particularly effective, or not helpful at all?

ALCOHOL AND DRUG

Have you ever made a decision to cut down on or quit using alcohol or other drugs? yes no

Has anyone ever been annoyed about your use of alcohol, prescription medications or other drugs?

yes no

Have you ever felt guilty about your use of alcohol, prescription medication or other drugs?

yes no

Have you ever experienced any of the following in connection with your use of alcohol, prescription medications or other drugs? Check any that apply.

- financial problems relationship problems work problems blackouts cravings
- increased tolerance physical problems emotional problems withdrawal symptoms

CULTURAL/ETHNIC

Race/ethnic group _____

Ethnic/racial issues that may require consideration _____

Sexual orientation issues that may require consideration _____

SPIRITUAL/RELIGIOUS

Active membership in organized religious group(s) _____

How does your religion/ spirituality affect your daily life? _____

Religious/spiritual issues that may require consideration _____

EDUCATION

Highest grade completed _____ Did you graduate from high school/GED? yes no

Did you attend college or technical school? yes no If yes, what degree?

associate bachelor master doctorate other _____

What was the focus of your studies? _____

EMPLOYMENT

Occupation _____ Employer _____

full-time part-time employed since _____ student

homemaker volunteer retired since _____ disabled since _____

Job satisfaction level? _____ How long at previous job? _____

Are you having any problems at workplace? yes no

Specify: _____

MILITARY SERVICE

yes no Type of discharge _____

Exposure to traumatic events, loss of life, bloodshed yes no If yes, please describe _____

FINANCIAL

Are you having financial problems? yes no If yes, please describe:

LEGAL HISTORY

Have you ever had involvement with the legal system? yes no If yes, please describe:

Do you have any current pending legal charges? yes no If yes, please describe:

Are you on probation or parole? yes no Have you ever been in jail? yes no

Client signature _____

Date _____

Reviewed/completed by clinician _____

Date _____

Reviewed/updated _____

Date _____