PLEASE PRINT

Name _____ Today's Date _____

Why are you coming for treatment now/today? _____

What do you need treatment to do for you? _____

What are your personal strengths: _____

List who (family, friends, etc.) you would like involved in your treatment. (No one will ever be contacted without your permission.)

_____ _____

_____ _____

_____ _____

Where do you want to have meetings to talk about your treatment needs? ☐The HPI clinic I'll go to ☐ Another private place

Where? _____

Put an "X" through the best times to schedule your appointments and talk about your wishes in treatment:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9am-5pm	9am-5pm	9am-5pm	9am-5pm	9am-5pm	9am-5pm
5pm-9 pm	5pm-9 pm	5pm-9 pm	5pm-9 pm	5pm-9 pm	1pm-4pm

Are family or friends aware of your decision to come here? ☐No ☐Yes

Limitations Affecting Treatment

Do you have a disability or limitation which may keep you from participating in treatment (for instance, a hearing or visual problem)?
☐No ☐Yes

If Yes, please explain: _____

Is English your primary language? ☐Yes ☐ No If no, what is your primary language? _____

Mental Health

During the past month, have you felt depressed, sad, or hopeless most days? ☐Yes ☐No
Have you lost interest in or got less pleasure from things you used to enjoy? ☐Yes ☐No
Do you feel like you are a nervous person? ☐Yes ☐No
Is it hard for you to control your worry? ☐Yes ☐No
Do you ever feel hyper or high (like on drugs) even though you haven't taken any? ☐Yes ☐No
Do you have times where your thoughts race or you have less need for sleep lasting more than 1 week? ☐Yes ☐No

Substance Use

How often do you have an alcoholic drink? ☐Never ☐ 1 month or less ☐2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

How many alcoholic drinks do you have on a typical day ? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6
☐ 7 or 9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion? ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

How many times in the past year have you used an illegal drug, including marijuana?
☐None ☐ 1 or more times

Do you use tobacco? ☐No ☐Yes If Yes, do you want to quit? ☐No ☐Yes

Trauma History
Have you been exposed to or threatened with any of the following?
☐ Domestic, physical, emotional, sexual abuse/violence ☐ Bullying ☐ Death
☐ Serious harm or injury ☐ An event you couldn't cope with

Have you ever abused another person? ☐No ☐Yes If Yes, who, how and when: _____

_____

Treatment History
Have you been in treatment before? ☐No ☐Yes If Yes:

Mental health Where: _____ When: _____
Where: _____ When: _____
Substance use Where: _____ When: _____
Where: _____ When: _____

Do you go to self-help groups? ☐No ☐Yes
If Yes, what and how often: _____

Barriers to Treatment
What may stop you from coming to treatment? ☐ Transportation ☐ Not Remembering
☐ Family Issues ☐ No Support
☐ Treatment days/times not good for me

FAMILY HISTORY

	OCCUPATION	YEAR IF DECEASED	DECRIBE YOUR RELATIONSHIP WITH THEM
Mother			
Stepmother			
Father			
Stepfather			

Number of brothers _____ sisters _____

If deceased, give year/cause of death _____

Describe relationship with siblings: _____

Culture and Ethnicity, Spirituality, Religion

How does your ethnic group influence your life? _____

List any cultural, ethnic (heritage), or spiritual concerns that might affect your treatment, or helps in deciding which therapist sees you, or the day and time of your appointments:

_____

Relationships

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you comfortable with your: Sexuality: ☐No ☐Yes Gender: ☐No ☐Yes

Are you currently involved in a long term relationship (other than marriage)? ☐Yes ☐No If Yes, length of time: _____

Check which best describes the quality of your present relationship: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Check areas which you now have conflict: ☐Money ☐Friends ☐Job ☐ Family ☐Sex ☐Communication ☐Legal problems ☐Alcohol/drug use ☐Mental health problems

Other _____

List the names and ages of your children: _____

_____

First relationship / marriage: _____
Age/date # of children If divorced, date

Second relationship / marriage: _____
Age/date # of children If divorced, date

Who currently lives with you? _____

Recreation/Socialization

How would you describe your friendships? ☐ No friends ☐ Just people I know a little ☐ Both close friends and people I know a little

Describe what you do each day: _____

_____

What recreational activities do you enjoy? _____

_____

Education

Circle highest grade completed in school: 6 7 8 9 10 11 12 13 14 15 16 17 18 19+

Did you attend trade/ technical school? ☐No ☐Yes If Yes, area of study: _____

Were you ever in special education classes? ☐No ☐Yes Are you currently in school: ☐No ☐Yes

Employment

Are you employed now? ☐No ☐Yes If Yes, where: _____

Position: _____ How long have you held this job? _____

Legal

Have you ever been arrested? ☐No ☐Yes

	Date	Offense	Status/Result
If Yes, list:			

Do you have a case pending in court? ☐No ☐Yes

Are you on probation/parole at this time? ☐No ☐Yes

If Yes, dates of probation/parole: _____ to _____

If Yes, dates of probation/parole: _____ to _____

Probation/parole officer: _____ _____ _____
Name Telephone # Address

Probation/parole officer: _____ _____ _____
Name Telephone # Address

Child Protective Services: Do you have an ☐ open ☐ closed case? ☐ No

Worker's Name: _____

Adult Protective Services: Do you have an ☐ open ☐ closed case? ☐ No

Worker's Name: _____

Financial
Do you currently have money problems? ☐No ☐Yes If Yes, explain: _____

_____

Parents of Children and Adolescents
As you may know, mental health and substance use problems can be devastating when left untreated. We all know that when an illness is treated early it is easier to find solutions. Please think about your children. What help do you need with your children and being able to come to treatment?

_____

Patient/Guardian (or informant) Signature: _____ Date: _____

Time: _____ am / pm

Signature and Credentials of Staff Reviewing this Form

_____ Date: _____

Time: _____ am / pm

☐ Patient/Member unable to complete form due to reading/writing skills - See Biopsychosocial Assessment for information.