Clinical Assessment Process, Part I
TO BE COMPLETED BY CLIENT

CLIENT FULL NAME_____
EMERGENCY CONTACT AND PHONE # _____
_____

MARITAL STATUS: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed ☐ Living together

SPOUSE/PARTNER NAME _____

IS IT OKAY TO CONTACT YOU AT WORK? ☐ Yes _____ (Phone #) ☐ No

IS IT OKAY TO CONTACT YOU AT HOME? ☐ Yes _____ (Phone #) ☐ No

NAME OF CHILDREN	AGE	LIVES WITH YOU?
_____	_____	☐ Yes
_____	_____	☐ Yes
_____	_____	☐ Yes
_____	_____	☐ Yes

BRIEFLY DESCRIBE YOUR REASON FOR CONTACTING US:

WHAT SITUATION(S) IN YOUR LIFE ARE PRESENTLY STRESSFUL?

IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING, (please check):

Depressed Mood ____ How Long?

Loss of pleasure in daily activities ____ How Long?

Change in appetite with significant weight change ____ How Long?

Change in sleep patterns
Sleep too much/too little ____ How Long?

Fatigue or loss of energy ____ How Long?

Feeling of worthlessness or low self-esteem ____ How Long?

Decreased ability to concentrate or make decisions ____ How Long?

Thoughts of dying or thoughts of suicide ____ How Long?

WHAT COUNSELING OR TREATMENT HAVE YOU HAD BEFORE?	DATE

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING PROBLEMS AT WORK? (check all that apply)

Overworked ____

Conflict with coworkers ____

Making mistakes/errors ____

Conflict with boss ____

Reprimand or disciplinary action ____

Difficulty concentrating ____

Absent from work more than usual ____

Feeling that things are not fair ____

Getting angry frequently, short fuse ____

Poor performance appraisal ____

Personal issues and family problems interrupt work ____

CLINICIAN USE ONLY

(More on reverse side)

CD SCREEN

TO BE FILLED OUT BY ADULTS (ages 18 and above)	(please circle)	
Have you ever felt like you should cut down on your alcohol or other drug use? (including prescription drugs)	Yes	No
Has a friend or relative discussed concerns about your use?	Yes	No
Have you ever felt guilty about your drinking or drug use?	Yes	No
Have you ever had to take a drink or use a drug the next day to steady your nerves?	Yes	No
Are you are a recovering alcoholic or recovering drug addict?	Yes	No
Is there a history of problems with alcohol or drug use in your family?	Yes	No

TO BE FILLED OUT BY ADOLESCENTS (ages 12 to 17)	(please circle)	
Have you ever used alcohol or drugs before or during school?	Yes	No
Have you ever missed school (or been truant) because of use or just to use?	Yes	No
Have you ever avoided non-users?	Yes	No

About how often do you get intoxicated?

_____

About how often do you use more than one drug when you get intoxicated?

_____

WHICH OF THE FOLLOWING ARE YOU USING:

	AMOUNT (DOSAGE)?	HOW OFTEN? (please check) 2 or more times a day	Once a day	weekly	monthly	Less than monthly	DATE OF LAST USE?
OVER THE COUNTER DRUGS (specify)							
_____	_____	___	___	___	___	___	_____
_____	_____	___	___	___	___	___	_____
_____	_____	___	___	___	___	___	_____
PRESCRIPTION DRUGS (SPECIFY)							
_____	_____	___	___	___	___	___	_____
_____	_____	___	___	___	___	___	_____
_____	_____	___	___	___	___	___	_____
ALCOHOL	_____	___	___	___	___	___	_____
MARIJUANA	_____	___	___	___	___	___	_____
COCAINE/CRACK	_____	___	___	___	___	___	_____
HEROIN	_____	___	___	___	___	___	_____
AMPHETAMINES (uppers, speed)	_____	___	___	___	___	___	_____
BARBITUATES (downers)	_____	___	___	___	___	___	_____
OTHER (specify)							
_____	_____	___	___	___	___	___	_____
_____	_____	___	___	___	___	___	_____

DESCRIBE ANY MEDICAL PROBLEMS:

HOW LONG AGO WAS YOUR LAST PHYSICAL?

WHAT DO YOU HOPE TO ACCOMPLISH BY COMING HERE?

DATE COMPLETED? _____