ADULT SELF-ASSESSMENT

Date:_____ Form completed by:_____ Relationship to patient:_____

Referral Source:_____ Tel #:_____

Name of Patient:_____ Sex: ☐M ☐F

Date of birth:_____ Age:_____ Social Security #:_____

Place of birth:_____ Primary Language:_____ Occupation:_____

Home Phone: _____ Work phone:_____ Cell Phone:_____

Home address:_____

_____

City MA Zip Code

Health Insurance:_____ Subscriber:_____

_____

In case of emergency, notify:_____ Tel #:_____

Relationship:_____ Is this person aware that you are receiving services at WBH? ☐ Yes ☐ No

Please note that by providing us with this emergency contact's information, you are giving WBH the right to contact this person at anytime if we have determined that the above patient is in an emergency situation.

PRESENTING ISSUES:

Please explain why you have chosen to seek counseling and/or medication evaluation at this time:

_____

_____

_____

Do any of the following currently apply to you?

√		√	Problem/Concern	√	Problem/Concern	√	Problem/Concern
	Depressed		Thoughts of Hurting Self		Phobic/Fearful		Losing Track of Time
	Low Energy		Thoughts of Hurting Others		Nauseated		Can't Stop Unpleasant Thoughts
	Low Self Esteem		Sadness/Grief		Fear of Losing My Mind		Angry/Frustrated
	Poor Concentration		Stress		Obsessive Thoughts		Easily Agitated/Annoyed
	Hopelessness		Anxiety/Panic		Compulsive Behaviors		Ignoring Rules
	Worthlessness		Heart Pounding/Racing		Racing Thoughts		Blaming Others
	Guilt		Chest Pain		Overspending		Frequently Arguing/Fighting
	Sleeping Less		Trembling/Shaking		Gambling		Using Drugs
	Sleeping More		Sweating		Delusions/Hallucinations		Using Alcohol
	Eating Less		Tingling/Numbness		Confusion		Blacking Out
	Eating More		Chills/Hot Flashes		Nothing Feels Real		Physically Sick all the Time
	Isolating/Withdrawal		Fear of Dying		Nightmares		Sexual Abuse
	Lonely		Relationship Problems		Family Problems		Physical Abuse
	Other Problems:						

How long have these issues existed? (# of weeks, months, years)_____

_____

Is there anything that you think may have led up to your current difficulties?_____

_____

MEDICAL INFORMATION:

Primary Care Physician:_____ Practice Name:_____

Tel #:_____ Date of last physical:_____ Date of next appointment:_____

√	Symptom/Concern	For How Long?	Are You Receiving Treatment For This Problem? Explain:
	Frequent Or Severe Headaches		
	Dizziness / Vertigo		
	Convulsions or Seizures		
	Hypertension		
	Vision Problems		
	Hearing Problems		
	Smelling Or Taste Problems		
	Thyroid Problems		
	Persistent Cough		
	Chest Pain		
	Shortness of Breath / Asthma		
	Chronic Fatigue		
	Sleep Disturbance		
	Nausea / Vomiting / Diarrhea		
	Abdominal Pain		
	Constipation		
	Urinary Problems		
	Arthritis		
	Diabetes		
	Obesity		
	Walking / Movement Problems		
	Other:		

What illnesses or surgeries have you had in the past? _____

_____

Do you exercise? ☐ Yes ☐ No If yes, how much per week?_____ What do you do?_____

Do you smoke? ☐ Yes ☐ No How long have you smoked?_____ How much do you smoke per day?_____

How would you rate your health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please indicate your birth family's medical and psychiatric history below:

Health Issue	Birth Mother	Birth Mother's Family	Birth Father	Birth Father's Family	Siblings (who?)	Other Relatives (who?)
Allergies						
Asthma / Emphysema						
Diabetes						
Heart Condition						
Mental Retardation						
Seizure Disorder						
Depression						
Schizophrenia						
Other Psychiatric Illness						
Trauma / PTSD						
Learning Disability						

Behavioral Problems						
Alcohol Abuse						
Drug Abuse						
Other Illness (Explain)						

SUBSTANCE ABUSE/GAMBLING HISTORY: ☐ Yes ☐ No

Substance	Date of last use	Age of first use	Method of use	Amount/frequency of use	Type
Alcohol					
Marijuana					
Tobacco					
Cocaine					
Crack					
Heroin					
Sedatives					
Amphetamines					
Prescription drugs					
Internet					
Video games					
Other					

Have you ever:

Lost a job, become disorderly, fought, or got into trouble while using substances ☐ Y ☐ N

Considered yourself to have an addiction ☐ Y ☐ N

Lost friends or relationships due to your addiction ☐ Y ☐ N

Attended AA, NA or other self help groups ☐ Y ☐ N

Tried to quit using alcohol, drugs, internet, or video games ☐ Y ☐ N

Felt that you needed substance abuse treatment ☐ Y ☐ N

Been referred to substance abuse treatment before (when?_____) ☐ Y ☐ N

Borrowed money in order to gamble or cover lost money ☐ Y ☐ N

Thought you might have a gambling problem or been told that you might ☐ Y ☐ N

Been untruthful about the extent of your gambling, or hid it from others ☐ Y ☐ N

Tried to stop or cut back on how much or how often you gamble ☐ Y ☐ N

Tried to quit smoking (Tobacco) ☐ Y ☐ N

Are you interested in receiving help to quit smoking now ☐ Y ☐ N

List any medications you are currently taking for medical and psychiatric purposes:

Medication	Dosage	Prescribed by:	Reason?	How long on this med?	Positive or Negative Responses?

Are you allergic to any medications? ☐ Yes ☐ No If you, please list:_____

_____

PSYCHIATRIC TREATMENT:

Are you currently receiving outpatient psychiatric services, please indicate services below:

√	Type if Psychiatric Service:	Name/Tel # of Clinician/Clinic	Starting Date:
	Medication Management		
	Individual Therapy		
	Group Therapy		
	Family Therapy		
	Day Treatment		
	Residential		
	Other:		

If you have previously seen a counselor or psychiatrist/prescriber before, please describe below:

Dates of Treatment	Name / Tel # of Clinician:	Describe Symptoms Treated:

If you have ever been hospitalized for psychiatric symptoms, please describe below:

Dates of Treatment	Name of Hospital	Describe Symptoms Treated:

Do you have a personal or family history of domestic violence, physical/emotional/sexual abuse or neglect? ☐ Yes ☐ No

Please explain: _____

_____

PATIENT NAME:

How you or your family received counseling or other services to address the above abuse or neglect? ☐ Yes ☐ No

Please describe (include dates):

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Live with Significant Other ☐ Widowed

# of marriages:_____ Length of current marriage/relationship:_____ Length of previous marriages:_____

If widowed, date and cause of spouse's death:_____

With whom do you spend most of your time?_____

What are your hobbies and interests?_____

Current Living Situation: ☐ Rent ☐ Own ☐ Other (explain :)_____

How long at this residence?_____ Who lives with you?_____

If you have living children, how many? Birth children____ Adopted children_____ Step children_____Other_____

Deceased children? ☐ Yes ☐ No Please explain (include date/circumstances)_____

# of Pregnancies:_____ # of incomplete pregnancies:_____ Date/circumstances of incomplete pregnancies:_____

Psychological or medical issues for living children? Please list below:

Name of child	Age	Diagnosis	Date of diagnosis	Receiving treatment?

Do your children currently or historically have behavioral problems? Please explain (include police involvement if applicable):_____

Is there DSS involvement? ☐ Yes ☐ No Please explain (indicate length of involvement):_____

DSS Office:_____ DSS Worker:_____ Phone:_____

EDUCATION

Graduated from: ☐ High school ☐ College ☐ Graduate School ☐ Doctorate Program ☐ Job Training

☐ Other (certification, GED):_____

Do you have an interest in pursing educational opportunities? ☐ Yes ☐ No Explain:_____

Are current psychiatric or medical issues interfering with your ability to go to school? ☐ Yes ☐ No

Explain:_____

VOCATIONAL HISTORY

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

How long have you been employed there?_____ What is your current position?_____

How many hours do you work each week? _____ Do you enjoy this job? ☐ Never ☐ Occasionally ☐ Usually

Describe your relationship with your current supervisor/boss? ☐ Difficult ☐ Manageable ☐ Enjoyable

If not employed, for how long?_____ Reason for unemployment:_____

_____

_____

Who was your last employer?_____ How long were you there?_____

What was your position?_____ Why did you leave?_____

Have you ever served in the Military? ☐ Yes ☐ No Branch:_____ Discharge Status: _____

Describe work history: ☐ Consistent ☐ Irregular/Sporadic ☐ Frequent Job Loss ☐ Numerous Jobs

Are current psychiatric or medical issues interfering with ability to work? ☐ Yes ☐ no Please explain:_____

_____

Financial Status: ☐ Comfortable ☐ Some Stress ☐ Severe Stress

Is there anything else that would be important for WBH to know in order to best meet your clinical needs?_____

_____

_____

_____

_____

Please bring this completed form with you on the day of your appointment.
If you would prefer to return this form to Waltham Behavioral Health prior to your appointment, please fax to:
617-969-6334

PATIENT NAME: