WALTHAM BEHAVIORAL HEALTH, 210 BEAR HILL RD SUITE 202, WALTHAM, MA 02451

ADULT SELF-ASSESSMENT

NOTE: This Information is confidential.

Demographic Information:

Name: Date:

Date of Birth: Relationship Status:

Age: SSN:

Gender: ◯ M ◯ F ◯ Transgender

Home/Mobile Phone: Is it ok to leave a message for you at this number? Y / N

Work Phone: Is it ok to leave a message for you at this number? Y / N

Email: Is it ok to email you? Y /N

Mailing Address:

Emergency Contact Name & Relationship:

Emergency Contact Phone:

How were you referred?

Is this person aware that you are receiving services at WBH? Y / N

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

Pharmacy Name: Phone:

PRESENTING ISSUES:

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

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 some per day?

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

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BEHAVIOR – CIRCLE ANY OF THE FOLLOWING BEHAVIORS THAT APPLY TO YOU:

Overeat	**Suicidal attempts**	**Can't keep a job**	**Take drugs**	**Compulsions**
Insomnia	**Vomiting**	**Smoke**	**Take too many risks**	**Odd behavior**
Withdrawal	**Lack of motivation**	**Drink too much**	**Nervous tics**	**Eating problems**
Work too hard	**Procrastination**	**Sleep disturbance**	**Crying**	**Impulsive reactions**
Phobic avoidance	**Outbursts of temper**	**Loss of control**	**Aggressive behavior**	**Concentration difficulties**

FEELINGS – CIRCLE ANY OF THE FOLLOWING FEELINGS THAT APPLY TO YOU:

Angry	**Guilty**	**Unhappy**	**Annoyed**	**Happy**	**Bored**	**Sad**
Conflicted	**Restless**	**Depressed**	**Regretful**	**Lonely**	**Anxious**	**Hopeless**
Contented	**Fearful**	**Hopeful**	**Excited**	**Panicky**	**Helpless**	**Optimistic**
Energetic	**Relaxed**	**Tense**	**Envious**	**Jealous**	**Other:**	_____

PHYSICAL – CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT APPLY TO YOU:

Headaches	**Stomach trouble**	**Skin problems**	**Dizziness**	**Tics**
Dry mouth	**Palpitations**	**Fatigue**	**Bumping or itchy skin**	**Muscle spasms**
Twitches	**Chest pains**	**Tension**	**Back pain**	**Rapid heart beat**
Sexual disturbances	**Tremors**	**Unable to relax**	**Fainting spells**	**Blackouts**
Bowel disturbances	**Hear things**	**Excessive sweating**	**Tingling**	**Watery eyes**
Visual disturbances	**Numbness**	**Flushes**	**Hearing problems**	**Don't like being touched**

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

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

_____

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						

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Other Psychiatric Illness						
Trauma/PTSD						
Learning Disability						
Behavioral Problems						
Alcohol Abuse						
Drug Abuse						
Other Illness (Explain)						

MEDICAL INFORMATION:

Primary Care Physician:_____ Tel#:_____

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

X	Symptoms/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:_____		

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

Medication	Dosage (mg)	Prescribed by	Reason?	How long on this Med?	Positive or Negative Responses?

Are you allergic to any medications? ◯ Yes ◯ No Please list:_____

_____

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:					

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Have you ever:

Lost a job, become disorderly, fought, or got into trouble while using substances	◯ Yes	◯ No
Consider yourself to have an addiction	◯ Yes	◯ No
Lost friends or relationships due to your addiction	◯ Yes	◯ No
Attended AA, NA, or other self-help groups	◯ Yes	◯ No
Tried to quit using alcohol, drugs, internet, or video games	◯ Yes	◯ No
Felt that you needed substance abuse treatment	◯ Yes	◯ No
Been referred to substance abuse treatment before (when?_____)	◯ Yes	◯ No
Borrowed money in order to gamble or cover lost money	◯ Yes	◯ No
Thought you might have a gambling problem or been told that you might	◯ Yes	◯ No
Been untruthful about the extent of your gambling, or hid it from others	◯ Yes	◯ No
Tried to stop or cut back on how much or how often you gamble	◯ Yes	◯ No
Tried to quit smoking (Tobacco)	◯ Yes	◯ No
Are you interested in receiving help to quit smoking now	◯ Yes	◯ No

PSYCHIATRIC TREATMENT:

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

X	Type of 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:

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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? ◯ Y ◯ N

Please explain:_____

_____

_____

Have you or your family received counseling or other services to address the above abuse or neglect? ◯ Y ◯ N

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:__

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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 DCF 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:_____

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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: 781-915-0755 or info@walthambehavioralhealth.org

Patient Name:_____