**HERON RIDGE ASSOCIATES**
**PERSPECTIVES OF TROY COUNSELING CENTERS** ***ADULT***
**SCREENING INFORMATION**
**Please Print Clearly**

**Dx_______________**

**THIS SHEET MUST BE FILLED IN COMPLETELY**

Readmit: __Yes __No

Date______________ Client's Social Security #___________________________________ Case #________

Client's Last Name______________________________________ First Name_________________MI______

Address________________________________ City_______________ State________ Zip_________

Telephone (Home)_______________________ (Work)___________________ (Cell)__________________

**Ok to leave messages? Home: ___yes ___no Work: ___yes ___no Cell: ___yes ___no**

Birthdate_____/_____/______ Age__________ Gender __F __M Race _____________

Email address (used for marketing purposes only) __________________________________________________

**Emergency Information**

In case of emergency, contact:

Name (1) _______________________________ Relationship_____________ Phone___________________

Address________________________________ City____________________ State________ Zip_________

Name (2) _______________________________ Relationship_____________ Phone___________________

Address________________________________ City____________________ State________ Zip_________

Physician_________________________________________________________ Phone___________________

Address________________________________ City____________________ State________ Zip_________

Other Physician___________________________________________________ Phone___________________

**Employment Information** (If client is a child, use parent's employment)

Client/Guardian: Place__________________________________ Occupation_______________ Hrs____

Spouse: Place__________________________________ Occupation_______________ Hrs____

**Insurance Information**

Primary Insurance_______________________________

Contract/ID#___________________________________

Group/Acct#___________________________________

Subscriber_____________________________________

Subscriber Social Security #______________________

Subscriber Date of Birth _________________________

Client's relationship to Subscriber (1)

__Self __Spouse __Son/Daughter

Secondary Insurance______________________

Contract/ID#____________________________

Group/Acct#_____________________________

Subscriber______________________________

Subscriber Social Security #________________

Subscriber Date of Birth___________________

Client's relationship to Subscriber (2)

__Self __Spouse __Son/Daughter

**Referral Source**

How did you hear of our clinic (or from whom)?______________________________________________________

Address________________________________ City____________________ State________ Zip_________

Phone_________________________________

**Heron Ridge Associates**
**Perspectives Counseling Centers**

**Personal History**

**-Adult-**

**Client's Name** ______________________________ **Date** ____________

Address ______________________ City __________ State _____ Zip ________

**If you need any more space for any of the questions please use the back of the sheet.**

Do you (client) have a __conservator __guardian __representative payee __personal representative
__No __Yes If Yes: Name______________________Phone____________
Address______________________________________

Is someone coordinating your services (e.g. legal, mental health, physical)?
__No __Yes If Yes: Name______________________Phone____________
Address______________________________________

**Primary reason(s) for seeking services**

| | | | |
|---|---|---|---|
| ___ Anger management | ___ Anxiety | ___ Coping | ___ Depression |
| ___ Eating disorder | ___ Fear/phobias | ___ Mental confusion | ___ Sexual concerns |
| ___ Sleeping problems | ___ Addictive behaviors | ___ Alcohol/drugs | ___ Past Trauma |

Other mental health concerns (specify) ______________________________________

______________________________________________________________

How old were you when you first felt these symptoms? ____________________________

What are your goals for therapy? (What outcome(s) would you like to take place?)____________

______________________________________________________________

Any additional information that would assist us in understanding your concerns or problems________

______________________________________________________________

**Behavioral/Emotional**

Please check behaviors and symptoms that occur to you more often than you would like them to:

| | | |
|---|---|---|
| ___ Alcohol dependence | ___ Gambling | ___ Paranoid |
| ___ Aggressive (__verbal __physical) | ___ Hallucinations | ___ Phobias/fears |
| ___ Anger | ___ Hearing Voices | ___ Racing Thoughts |
| ___ Anxiety | ___ Heart palpitations | ___ Rapid Speech |
| ___ Avoiding people | ___ High blood pressure | ___ Recurring thoughts |
| ___ Bizarre experiences | ___ Homicidal Ideation | ___ Sexual addiction |
| ___ Chest pain | ___ Hopelessness | ___ Sexual difficulties |
| ___ Computer addiction | ___ Impulsivity | ___ Sick often |
| ___ Depression | ___ Irritability | ___ Sleeping problems |
| ___ Disorganized thoughts | ___ Judgment errors | ___ Social Difficulties |
| ___ Disorientation | ___ Loneliness | ___ Speech problems |
| ___ Distractibility | ___ Low self esteem | ___ Suicidal thoughts |
| ___ Drug dependence | ___ Memory impairment | ___ Trembling |
| ___ Eating disorder | ___ Overly Sensitive | ___ Withdrawing |
| ___ Emotional outbursts | ___ Panic attacks | ___ Worrying |
| ___ Fatigue | | |

___ Other ______________________________________________________

Please describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) ____________________________________________________________
____________________________________________________________

**What areas of your life are being affected by the above?**

**Social**
__ Unable to form or maintain friendships
__ Withdrawal from family and friends (excessive desire to be alone)
__ Increased conflict with others
__ Loss of interest in social activities
__ Phobia

**Occupational**
__ Unable to maintain job
__ Absenteeism
__ Conflicts with co-workers
__ Tardiness
__ Reduced productivity
__ Disciplinary action for poor performance

**Academic**
__ Failing grades
__ Truancy
__ Tardiness
__ Detention
__ Reduced productivity at school
__ Fighting/conflicts with students/teachers

**Physical**
__ Decreased energy/fatigue
__ Difficulty getting out of bed
__ Insomnia
__ Substantial weight loss or gain
__ Decreased/increased appetite
__ Frequent illness

**Affective Distress**
__ Crying spells
__ Irritability
__ Concentration problems
__ Disorganized thoughts
__ Feeling overwhelmed with emotions

**Affective Distress (Continued)**
__ Worrying that interferes with the ability to concentrate
__ Anger/rage
__ Emotional meltdowns/breakdowns
__ Memory problems

**Counseling/Prior Treatment History**

| | Yes | No | When | Where | Overall experience |
|---|---|---|---|---|---|
| Mental health counseling | ____ | ____ | ________ | ________ | ________ |
| | ____ | ____ | ________ | ________ | ________ |
| Psychiatrist for medication | ____ | ____ | ________ | ________ | ________ |
| Suicidal/Homicidal thoughts | ____ | ____ | ________ | ________ | ________ |
| Suicidal/Homicidal attempts | ____ | ____ | ________ | ________ | ________ |
| Drug/Alcohol treatment | ____ | ____ | ________ | ________ | ________ |
| Mental Health | ____ | ____ | ________ | ________ | ________ |
| Hospitalizations | ____ | ____ | ________ | ________ | ________ |
| Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) | ____ | ____ | ________ | ________ | ________ |

Any immediate family in treatment currently? If yes, whom and where? ______________________________

Previous mental health diagnosis(es)____________________________________________________________

**Family Information**

Your current relationship status:

___ Single
___ Legally married
___ Widowed
___ Other ____________________________________________________________
___ Divorce in process
___ Separated
___ Annulment
___ Unmarried, living together
___ Divorced
___ Engaged

Assessment of relationship with significant other (if applicable) __ Good __ Fair __ Poor __ N/A

Would you like your family to be involved in your treatment? __ No __ Yes
If yes, please describe the extent of involvement: ________________________________________

| | Name | Age | (Indicate if step or adopted) | Living? Yes/No | Living with you? Yes/No |
|---|---|---|---|---|---|
| Spouse | ______ | ______ | ______ | ______ | ______. |
| Children | ______ | ______ | ______ | ______ | ______. |
| | ______ | ______ | ______ | ______ | ______. |
| | ______ | ______ | ______ | ______ | ______. |
| | ______ | ______ | ______ | ______ | ______. |
| | ______ | ______ | ______ | ______ | ______. |
| Mother | ______ | ______ | ______ | ______ | ______. |
| Father | ______ | ______ | ______ | ______ | ______. |

Significant others in your life (brothers, sisters, grandparents, relatives, step-relatives):
Please specify relationship.

| Relationship | Name | Age | Living? Yes | No | Living with you? Yes | No |
|---|---|---|---|---|---|---|
| ______ | ______ | ______ | ____ | ____ | ____ | ____ |
| ______ | ______ | ______ | ____ | ____ | ____ | ____ |
| ______ | ______ | ______ | ____ | ____ | ____ | ____ |

**Parental Information** (check those which apply)

__Parents legally married __Mother remarried Number of times _______
__Parents have been separated __Father remarried Number of times _______
__Parents ever divorced (Your age at the time of divorce) _________

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.) ______________________________

**Development**

Are there special, unusual, or traumatic circumstances that occurred in your life? __ No __ Yes

If Yes, please describe______________________________

Has there been a history of child abuse? __ No __ Yes

If Yes, which type(s)? __ Sexual __ Physical __ Verbal

Other childhood issues: __Neglect __Inadequate nutrition __Poor health__ Other (please specify) _________

______________________________

How old were you at the time of abuse? ______________________________

Comments regarding childhood development______________________________

______________________________

Parenting style of parents:

__ Authoritative (strict, but fair) __ Authoritarian (overly strict) __ Permissive (few rules)

In your developmental milestones (walking, talking, onset of puberty), were you: __ on time __ early __ late

**Social Relationships**

Check how you generally get along with other people (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower
____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive
____ Other (specify)______________________________

Do you currently have supportive friendships? __Yes __ No

Sexual orientation___________________Comments____________________________________________
Sexual dysfunctions? __ No ___ Yes
If Yes, describe____________________________________________________________________

**Other History of Trauma**

Any history of being abused by others? __No __Yes
__ Experienced or __ Witnessed
__ Neglect __ Abuse ( __ Emotional __ Physical __ Verbal __ Sexual)
__ Violence __ Sexual assault

Explain: ______________________________________________________________________
Any current behaviors or history as sexual perpetrator? __No __Yes
If Yes, describe____________________________________________________________________

Do you have a history of social problems (e.g. being bullied, bullying others)? ________________________

______________________________________________________________________________

**Cultural/Ethnic**

To which cultural or ethnic group, if any, do you belong?__________________________________________
Are you experiencing any problems due to cultural or ethnic issues? __No __Yes
If Yes, describe____________________________________________________________________
Other cultural/ethnic information______________________________________________________

**Spiritual/Religious**

How important are spiritual matters to you? __Not at all __Little __Moderate __Much
Are you affiliated with a spiritual or religious group? __No __Yes
If Yes, describe____________________________________________________________________
Were you raised within a spiritual or religious group? __No __Yes
If Yes, describe____________________________________________________________________
Would you like your spiritual/religious beliefs incorporated into the counseling? __No __Yes
If Yes, describe____________________________________________________________________

**Current Legal Status**

**Are you mandated for treatment? __ Yes __ No**
Are you involved in any active cases (traffic, civil, criminal)? __No __Yes
If Yes, please describe and indicate the court and hearing/trial dates and charges_____________________

______________________________________________________________________________
Are you presently on probation or parole? __No __Yes
If Yes, please describe______________________________________________________________

Probation officer name and telephone number: ______________________________________________

**Past Legal History**

| Traffic violations | ____ Yes | ___ No | DWI, DUI, etc. | ___ Yes | ___ No |
| --- | --- | --- | --- | --- | --- |
| Criminal involvement | ____ Yes | ___ No | Civil involvement | ___ Yes | ___ No |

If you responded Yes to any of the above, please fill in the following information:

| Charges | Date | Where (city) | Results |
| --- | --- | --- | --- |
| | | | |
| | | | |

**Education**

Fill in all that apply        Currently enrolled in school __ Yes   __ No

___ High school grad/GED    Average school grades (current or previous) ________________________
___ Vocational   Number of years __   Graduated ___ Yes ___ No   Major ________________________
___ College   Number of years __   Graduated ___ Yes ___ No   Major ________________________
___ Graduate   Number of years __   Graduated ___ Yes ___ No   Major ________________________
Other training ____________________________________________________________________

Special circumstances (e.g., learning disabilities, gifted)________________________________________

Literacy Level (if known)  __ Limited  (0-275)  __  Minimal (276 – 325)   __ High (326 and higher)

**Employment**

Begin with most recent job, list job history

| Employer | Dates | Title | Reason left the job | How often miss work |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Work Status**

__FT   __PT   __Temp   __Laid-off   __Disabled   __Retired   __Social Security   __Student
__Other (describe)____________________________________________________________________

**Current Annual Income**:  $_________________Personal income  $_________________Household Income

**Military**

Military experience? ___ Yes   ___ No        Combat experience? __Yes  __No   # of Tours _______

Branch________________________________   Discharge date__________________________________

Type of discharge__________________________Rank at discharge__________________________________

Family member in the service?  ___ Yes   ___ No   Who? ______________________________________

**Leisure/Recreational**

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

| Activity | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Medical/Physical Health Condition** (Check any problem areas you have or have had)

For each illness listed below, choose a single answer that best describes your health history:

| Condition | Currently | In Past | Never | Condition | Currently | In Past | Never |
|---|---|---|---|---|---|---|---|
| Abortion | | | | Loss of Consciousness | | | |
| Anemia | | | | Memory Loss | | | |
| Appetite Change | | | | Numbness | | | |
| Arthritis | | | | Pain (Daily, Longer than 2 weeks) | | | |
| Asthma | | | | Palpitations | | | |
| Back Pain | | | | Paralysis | | | |
| Blood In Stool | | | | Rheumatic Fever | | | |
| Blurred Vision | | | | Seizures | | | |
| Caffeine Use | | | | Shortness of Breath | | | |
| Chest Pain | | | | Skin Disease | | | |
| Chicken Pox | | | | Sleep Apnea | | | |
| Chronic Cough | | | | Sleep Difficulties | | | |
| Colitis or Irritable Bowel | | | | Stroke or TIA | | | |
| Confusion or Disorientation | | | | Swallowing Difficulty | | | |
| Constipation | | | | Dental Problems | | | |
| Diabetes | | | | Thyroid Disease | | | |
| Diarrhea | | | | Tuberculosis | | | |
| Dizziness | | | | Ulcers or Indigestion | | | |
| Emphysema | | | | Urination Difficulty | | | |
| Fainting | | | | Sexually Transmitted Disease | | | |
| Glaucoma | | | | Weakness | | | |
| Gluten Allergy | | | | Recent Weight Gain | | | |
| Head Injury | | | | Recent Weight Loss | | | |
| Headaches (Frequent) | | | | Malnutrition | | | |
| Hearing Loss | | | | Epilepsy | | | |
| Heart Disease | | | | Autoimmune Condition | | | |
| Miscarriage | | | | Hepatitis | | | |
| Infertility | | | | Energy Level | | | |
| Low Libido | | | | Other: | | | |
| Multiple Sclerosis | | | | | | | |

List any current health concerns______________________________________________________________

______________________________________________________________________________

List any recent health or physical changes______________________________________________________

**Please list all of your current prescription and non-prescription (over-the-counter) medications:**

| Name of your current medicine | What do you use it for? | When did you begin taking it? | What is the strength of each tablet or capsule? | What dose do you take, and how often? | Name of prescribing physician |
|---|---|---|---|---|---|
| Example: "Plavix" | High Cholesterol | 2005 | 75 mg | Once/day | Dr. Smith |
| | | | | | |
| | | | | | |
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**Please list all psychiatric medications that you have taken in the past:**

| Name of your previous medicine | What did you use it for? | How long did you take it? | When did you stop taking it? | Why was it stopped? | Was the medication effective? |
|---|---|---|---|---|---|
| Example: "Lexapro" | Depression | 1 month | 6 months ago | Condition improved | Yes/ No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Describe your overall compliance with the above medications___________________________________

**Please list all nutritional and herbal supplements that you currently take:**

_______________________________________________________________________________

**Medication Allergies**: _________________________________________________________________

Have you ever had any bad reactions (made you feel worse) to prior medications? (if so, specify):

_______________________________________________________________________________

Do you see a psychiatrist? Name: _________________________ Last appointment: ________________

Hospital of choice ____________________________________ Phone_______________________
Address __________________________________________________________________________

**Most recent examinations**

| Type of examination | Date of most recent visit | Reason/Results |
|---|---|---|
| Physical examination | __________________ | __________________________________________ |
| Doctor's visit | __________________ | __________________________________________ |
| Dental examination | __________________ | __________________________________________ |
| Vision examination | __________________ | __________________________________________ |
| Hearing examination | __________________ | __________________________________________ |
| Most recent surgery | __________________ | __________________________________________ |
| Other surgeries | __________________ | __________________________________________ |
| Upcoming surgeries | __________________ | __________________________________________ |

**Self Care**
**Sleep**:
How many hours of sleep do you receive in a typical night? ______ Hours
Any problems: ___ Falling asleep __ Staying asleep How many hours do you need to feel rested? _____ Hours

**Nutrition**:
How many consistent meals are you eating/day? ________________________________________
Quantity consumed at meals ___ Low ___ Medium ___ High
Explain: ____________________________________________________________
Quality of food eaten ___ Low ___ Medium ___ High
Explain: ____________________________________________________________

**Exercise**:
Do you receive regular exercise? Explain type: ________________________________________
How often ________/week/month
How long do you exercise? _________min/hours

**Disabilities**
Do you have any physical/psychological disabilities? __ No __ Yes
If Yes, describe and note how it affects your physical and/or psychological functioning and how you adjust to your disability(ies) ____________________________________________________________
Have you made an adjustment to the disability/disorder? __ Yes __ No
Do you have any need for assistive technology in the provision of counseling services?
__ No __ Yes Explain ____________________________________________________________

**List <u>Your</u> history of mental illness/substance abuse:**

| **Personal** History of: | Currently | In the Past | Never |
|---|---|---|---|
| Substance Abuse | | | |
| Depression | | | |
| Anxiety | | | |
| Manic Depression (Bipolar) | | | |
| Suicide/Homicide Attempt | | | |
| Nervous Breakdown | | | |
| Addictive Behaviors (eating, sexual, etc.) | | | |
| Psychiatric Hospitalizations | | | |

**List <u>Family</u> history of mental illness/substance abuse:**
**Mother = mo; Father = fa; Sibling = s; Grandmother = gm; Grandfather = gf**

| **Family** History of: | Currently | In the Past | Never |
|---|---|---|---|
| Substance Abuse | | | |
| Anxiety | | | |
| Depression | | | |
| Manic Depression (Bipolar) | | | |
| Suicide/ Homicide Attempt | | | |
| Nervous Breakdown | | | |
| Addictive Behaviors (eating, sexual, etc.) | | | |
| Psychiatric Hospitalizations | | | |

Do any of these illnesses significantly challenge or limit your ability to function at work or at home?
If yes, please provide details:

____________________________________________________________

____________________________________________________________

**Substance Use History**

| Drug Type | Method | Age first Use | Age Last Use | Age of Onset/ of Heavy Use | Number of days used in last 30 days | Used in the last 48 Hours ? | Used as a Prescription? | Date of Last Use | Amount Used Daily | Amount Used Weekly | Drug of Choice? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol | | | | | | | | | | | |
| Heroine | | | | | | | | | | | |
| Other Opiates/ Painkillers | | | | | | | | | | | |
| Barb/Sedatives/ Hypnotics | | | | | | | | | | | |
| Other Sedatives | | | | | | | | | | | |
| Tranquilizers | | | | | | | | | | | |
| Meth/Stimulants | | | | | | | | | | | |
| Cocaine | | | | | | | | | | | |
| Crack | | | | | | | | | | | |
| Hallucinogens/ PCP | | | | | | | | | | | |
| Cannabis | | | | | | | | | | | |
| Inhalants | | | | | | | | | | | |
| Antidepressants | | | | | | | | | | | |
| Over the Counter | | | | | | | | | | | |
| Nicotine | | | | | | | | | | | |
| Caffeine | | | | | | | | | | | |
| Steroids | | | | | | | | | | | |
| Methadone/Sub-oxone | | | | | | | | | | | |
| Benzodiazepines | | | | | | | | | | | |
| Other | | | | | | | | | | | |
| | | | | | | | | | | | |

**Substance(s) of preference**

1. ___________________________________ 3. ___________________________________

2. ___________________________________ 4. ___________________________________

Describe when and where you typically use substances___________________________________

_____________________________________________________________________________________

Describe any changes in your use patterns____________________________________________________

_____________________________________________________________________________________

Describe how your use has affected your family or friends (include their perceptions of your use)

_____________________________________________________________________________________

Reason(s) for use
____ Addicted ____ Build confidence ____ Escape ____ Self-medication
____ Socialization ____ Taste ____ Other (specify) ____________________________
How do you believe your substance use affects your life?_________________________________________
Who or what has helped you in stopping or limiting your use?______________________________________
Does/Has someone in your family present/past have/had a problem with drugs or alcohol?
____ Yes ___ No If Yes, describe_______________________________________________________

**Substance Abuse History Continued**

__ Has your use of alcohol or drugs interfered with your obligations at work?
__ Has your use of alcohol or drugs interfered with your obligations at school?
__ Has your use of alcohol or drugs interfered with your obligations at home?
__ Has your use of alcohol or drugs while driving a car or truck?
__ Have you used alcohol or drugs while operating machinery?
__ Have you ever been arrested as a result of drinking or using drugs?
__ Have you continued to use alcohol or drugs despite having problems caused by the effects of the substance?

__ Have you ever used more alcohol or drugs in order to achieve the desired effect?
__ Has there become a markedly diminished effect with the continued use of the same amount of the substance?
__ Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?
__ Have you ever used substances in larger amounts or over a longer period of time than was initially intended?
__ Have you attempted to cut down or control the amount of drinking or drug use without success?
__ Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?
__ Have important social, occupational, or recreational activities been given up or reduced because of your use of alcohol or drugs?
__ Have you continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur?

Do you feel suicidal at this time? __ No __ Yes
If Yes, please explain ____________________________________________________________

Do you feel homicidal at this time? __ No __ Yes
If yes, please explain ____________________________________________________________

Are you engaged in any risk taking behaviors? __No __Yes

If Yes, describe____________________________________________________________

____________________________________________________________

______________________________________ ______________________
Signature of person filling out form Date

**For Staff Use**
Therapist's comments ____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Therapist's signature/ credentials ______________________________Date ____/____/_____

Supervisor's comments ____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Physical exam: __Suggested __Not suggested
Supervisor's signature/credentials *___________________________________ Date __/____/________
(Certifies case assignment, level of care and need for exam)
*= The Medical Director's signature on the assessment form signifies his review of the information contained in this screening form.

Therapist's response to supervisor's remarks ______________________________________________
____________________________________________________________

Therapist's signature/credentials _____________________________ Date _____/____/_____
Rev 6/18