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NEW CLIENT ASSESSMENT

Client's Name: _____

D.O.B. _____ Gender: _____ Date: _____

Home Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone: _____ Work/Cellular Phone: _____

May I contact you at Home? By Mail? Y N By Phone? Y N

May I contact you at work? Y N

Contact in Emergency Situation: _____

Telephone Number: _____ Relationship: _____

Social Security #: _____ Employer: _____

Occupation: _____

Relationship Status: (circle) Single Married Separated Divorced Widowed Co-habitating

Partner's name: _____ Partner's Employer: _____

Insurance Provider: _____

Policy #: _____ Group #: _____

To be completed if Client is a Minor:

Parent/Guardian: _____

School: _____

What concern/s brings you to counseling? _____

_____

_____

_____

MEDICAL HISTORY

Primary Care Physician: _____

Telephone Number: _____

Currently under a medical physician's care? YES/NO

If YES, please describe current medical condition/s: _____

_____

_____

Medications currently used: circle if NONE

Medication	Dosage	Dr. Prescribing	Why Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitilizations (i.e., medical, Psychiatric, Chemical Dependency): NONE

Date/s	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Counseling or Chemical Dependency Treatment/Services: NONE

Facility/Therapist's Name	Date of Service	Reason for Treatment	Helpful (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____

CHEMICAL DEPENDENCY ASSESSMENT

Do you ever feel guilty about your drinking habits? Y N

If yes, please describe: _____

Have you ever attempted to reduce your alcohol intake? Y N

If yes, what was the outcome? _____

Do family members/friends ever complain about your drinking behaviors? Y N

Have you lost friends or alienated family members due to your drinking behaviors? Y N

Have you ever been reprimanded at work due to your drinking behavior? Y N

Have you been arrested for your drinking behavior? Y N

Do you ever end up drinking more than you intended? Y N

Can you stop drinking, without a struggle, after one or two drinks? Y N

How many drinks do you need to feel a "buzz"? __1-3 drinks __4-6 drinks __7-9 drinks __10 or more

How many drinks does it take to get drunk? __1-3 drinks __ 4-6 drinks __7-9 drinks __10 or more

How long is the longest time you have gone without drinking? _____

What happens to you when you don't have anything to drink? _____

Recreational (i.e. Illegal) and Prescription Drugs

Do you ever use illegal drugs? Y N

If yes, please list/describe illegal drugs you currently use: _____

_____

Do you ever take prescription medication in a way that is not advised (more than prescribed or more than advised)? Y N

Do you ever feel guilty about your drug use? Y N

If yes, please describe: _____

Have you ever attempted to reduce your drug us? Y N

If so, what was the outcome? _____

Do family members/friends ever complain about your drug use? Y N

Have you lost friends or alienated family members due to your behavior while using drugs? Y N

Have you ever been reprimanded at work due to your drug use? Y N

Have you been arrested for your behavior while using drugs? Y N

Do you ever end up taking more drugs than you intended? Y N

Can you stop taking drugs, without a struggle? Y N

Qhat quantity/amount of drugs is needed for you to feel a "high"? _____

How long is the longest time you have gone without using drugs? _____

What happens to you when you don't use drugs? _____

PERSONAL QUESTIONS

Do you currently feel suicidal (i.e., have thoughts of harming yourself in any way)? Y N

If yes, please describe your feelings/intent: _____

_____

Have you been suicidal in the past? Y N

If yes, please describe in detail: _____

_____

Have you ever attempted suicide or to seriously harm yourself? Y N

If yes, please describe in detail: _____

_____

Do you currently have the intent to harm, seriously hurt, or kill another individual? Y N

If yes, please describe in detail: _____

_____

Have you ever seriously harmed, purposefully, another individual? Y N

If yes, please describe in detail: _____

_____

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? Y N

If so, by whom? _____

Please describe what happened? _____

_____

Do you feel safe in your current relationship? Y N

If no, please explain further: _____

_____

Is there a partner from a previous relationship who is making you feel unsafe now? Y N

If so, whom? _____

Please explain further: _____

_____

Have you ever been sexually abused? Y N

If yes, please explain further: _____

_____