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REFLECTIVE SELF-REPORT OF FUNCTIONING AND MENTAL STATUS

PERSONAL DATA: **How were you referred? _____**

Name: _____ Age: ____ Gender: ____ Marital Status: S / M / D / Other

Current Relationship Status & Duration: _____

Number of Children: ____ Ages: _____ Children living at Home: _____ Children no longer with you: ____

Current Stressful Events: Relationship ____ Family problems ____ Family Illness ____ Legal ____ Financial ____ Other ____

Employer/Position? _____ School_____ Program of Study_____

Please list the major problems you would like to address, and rate the severity of each one per the below rating scale:

1 --------- 2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 --------- 10
Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse RATING

1._____ _____

2._____ _____

3._____ _____

What are the Goals you hope to reach by engaging in Counseling?

MEDICAL & OTHER HISTORY:

How would you rate your overall physical health? Excellent ___ Good ___ Fair ___Poor___

Do you have any serious medical conditions? Yes ____ No ____(If yes, please describe)

Please list any prescription medications you are taking:

Have you ever been hospitalized for medical or psychiatric reasons? ____(If yes, please describe)

Do you smoke? Yes ____ No ____

Do you drink Alcohol? Yes ____ No ____(If yes, what type, how much, how often, when was last drink consumed?)

Do you use recreational drugs? Yes ____ No ____(If yes, what type, how much, how often, when last used?)

Do you Exercise? Yes ____ No ____ (If yes, please describe)

Changes in Sleep Habits? Yes ____ No ____ (If yes, please describe)

Changes in Eating Habits? Yes ____ No ____ (If yes, please describe)

DAILY FUNCTIONING: Please estimate how many hours per week you typically spend doing the following:	**LIFELONG FUNCTIONING:** Please check the best and worst times during your lifespan:
Working in your primary job ____	**Age: Best Times Average times Worst Times**
Parenting/Caretaking of others ____	0-5 _____ _____ _____
Doing household chores, bills, etc ____	6-12 _____ _____ _____
TV, Movies ____	13-19 _____ _____ _____
Physical recreation or exercise of some kind ____	20-29 _____ _____ _____
Hobbies (crafts, games, music, dancing, reading, etc.) ____	30-39 _____ _____ _____
Social activity with friends, family ____	40-49 _____ _____ _____
Church, charity, spiritual or inspirational activities ____	50-59 _____ _____ _____
Quiet, non-productive, or relaxing time ____	60-69 _____ _____ _____
Other? ____	70-79+ _____ _____ _____

Have you ever engaged in counseling before (i.e, Individual, Family, Other)? Yes ____ No ____

Check any that reflect how you have been feeling: Sad ___ Isolated ___ Angry ___ Anxious ___ Frightened ___
Confused ___ Disconnected ___ Traumatized ___ Hopeless ___ Helpless ___ Worthless ___ Numb ___

Other feelings ? _____

WORST TIME IN LIFE & WHO HELPED YOU THROUGH IT? (Please briefly describe).

BEST TIME IN LIFE (Please briefly describe)

What have you done that you are MOST PROUD OF?

What are your personal STRENGTHS that help you cope when times are hard?

Who do you consider as part of your supportive network (i.e, friends, family members, others)?

Section A

Have you been consistently depressed or down, most of the day, nearly every day? Yes ____ No____ (If yes, please indicate how long you think you have been feeling this way? (Weeks ____ Months ____ Years ____)

Have you lost interest in most things that you used to enjoy? Yes ____ No_____ Since When/How Long? _____

Have you ever engaged in self-injurious behavior? Yes ____ No____ (If yes, briefly describe when/how)

Have you ever contemplated suicide? Yes ____ No____ (If yes, did you have a plan? Yes ____ No____)

If you have ever thought about suicide, what would stop you from acting on these thoughts?

Have you ever thought about physically hurting or killing someone else? Yes ____ No____ (If yes, briefly describe).

Have you ever had a period of time when you were feeling "up", hyper, or so energized that you got into trouble, had insomnia, or had other people comment that you were not your usual self? (Do not consider times during drug/alcohol use) Yes ____ No____

Have you ever been so irritable, grouchy or annoyed for several days that you had arguments, verbal or physical fights, or shouted at people outside your family? Yes ____ No____

(Please Initial:_____)

Section B

Have you ever felt intensely anxious, frightened, or uneasy for no obvious reason? Never ____ Occasionally _____ Often ____

During these times, did you experience any of the following? (Heart racing ____ Trembling ____ Dizziness ____ Other ____)

Did these intense feelings escalate and subside within 5-10 minutes ? Yes ____ No ____ Describe what worked to calm you?

Check any situations you experienced that cause you to feel anxious, frightened, uncomfortable or uneasy: (Crowds/Lines_____ Being alone and away from home ____ Crossing a bridge ____ Traveling (bus/train/plane/car) ____ Other _____)

Do any of these situations cause you to feel embarrassed or fearful of humiliation: (Speaking/Eating in public ____ Attending groups/classes/meetings ____ Attention in social situations (i.e., gatherings/parties ____ Other situations? _____

Have you worried excessively or been anxious about several things over the past 6 months? Yes ____ No____ (If yes, are these worries present most days? Yes ____ No____ (If yes, Please describe):

Do thoughts, impulses, or persistent/intrusive images bother you? Yes ____ No ____ (If yes, check any examples below that apply): Fear of acting impulsively that would be shocking or harmful to self/others? ____ Worrying about being dirty or having germs? ____ Obsessing with sexual thoughts, images or impulses? ____ Hoarding or Collecting lots of things? ____ Religious obsessions? ____ Other? _____

In the past month, check any of the following repetitive behaviors in which you engage without being able to resist doing it? Washing or cleaning excessively ____ Counting or checking things repeatedly ____ Repeating, collecting or arranging things ____; Other rituals? _____

Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that resulted in actual/threatened death or serious injury to you or someone else? Yes ____ No ____ (If yes, check any of the following that apply): Serious accidents ____ Death of someone close to you ____ Sexual or physical assault ____ Fire ____ Natural Disaster ____ Terrorism/War____

Have you re-experienced the traumatic event in a distressing way in the past month? Yes ____ No ____ (If yes, check any of the following that apply): Dreams/Nightmares ____ Intense recollections ____ Flashbacks ____ Physical reactions ____

Section C

Have your relatives or friends ever considered any of your beliefs or actions strange or unusual? Yes ____ No____

Have you ever believed that people were spying on you, plotting against you, or trying to hurt you? Yes ____ No____

Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear their thoughts? Yes ____ No____

Have you ever heard things other people couldn't hear, such as voices or sounds? Yes ____ No____

Have you ever had visions when you were awake or have you ever seen things other people couldn't see? Yes ____ No____

Section D

Have you ever felt you should cut down on your drinking or drug use? (Drinking: Yes ____ No____) (Drug Use: Yes ____ No____)

Have people annoyed you by criticizing your drinking or drug use? (Drinking: Yes ____ No____) (Drug Use: Yes ____ No____)

Section E

Have you ever lost considerable sums of money though gambling or had problems at work, in school, with our family and friends as a result of your gambling? Yes ____ No____

(Please Initial:_____)