Karie Klim, LMFT
Licensed Marriage and Family Therapist
3558 Round Barn Blvd, Suite 200 (234)

IDENTIFYING INFORMATION:	Name:	Date of Birth:
Health Plan/Insurance:	Member ID/Group #:	Age:
Other Agency Involvement/Conservatorship:		
Living Situation:		
Referral Source:	Significant Others:	

CLIENT GOALS & PRIORITIES/REASON FOR SEEKING HELP:

1)

2)

3)

4)

5)

TREATMENT BARRIERS (Things that will stand in the way of attending therapy appointments)**:**

1)

2)

3)

PRESENT SYMPTOMS (Sx)/BEHAVIORS (Bx):

	Current Sx/Bx	Date of Onset	Frequency		Circumstances/Precipitating Events
			(Estimated # of times)	(Per wk, mo, yr)	
1)					
2)					
3)					
4)					
5)					

Sleep Issues
# of Hours per night: _____

Check all that apply: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Early AM awakening
☐ Nightmares (describe):

Eating Issues
☐ Yes ☐ No

☐ Uncontrollable urge to eat ☐ Vomiting after eating
Has client had weight loss or gain? ☐ loss ☐ gain # of lbs: _____ Over what time frame?
Any other problems related to eating?

MENTAL HEALTH HISTORY:

Previous Counseling Tx Dates	***Provider Name(s)***	***Interventions/Treatment***	***Client Response(s) (****Effective/Not Effective)*
1)			
2)			
3)			

Medications:

Hospitalizations:

Family History of Mental Illness:

MEDICAL HISTORY: ***(complete entire section even if there is no medication)***

Current Psychiatric Medications (write "none" if none)	Dosage & Frequency	Purpose	Prescribing Physician	Type of MD (eg Psychiatrist, Internist, family doctor)	Date Started (if known)	Effectiveness (good, fair, poor)

Current Non-psychiatric Medications (write "none" if none): _____

☐ Yes ☐ no ☐ not applicable Cooperative with medication use? Explain, if no: _____
☐ Yes ☐ no Known adverse reactions to medication? _____
☐ Yes ☐ no Known allergic reactions? _____
☐ Yes ☐ no Current physical health conditions? _____
☐ Yes ☐ no Known chronic or life threatening illness (including HIV)? _____
☐ Yes ☐ no Does client have current **Physical Health** care providers (name of medical doctor, chiropractor, non-traditional, etc)? List all:

_____

Date(s) Last Seen: _____

☐ Yes ☐ no Does the client have a current **dentist**? _____
☐ Yes ☐ no Has the client seen the dentist in the past 6 months?

FAMILY PSYCHOSOCIAL HISTORY	Mother	Father
Socio-Economic Education Work Hx/Career Community Natural Supports Family Hx/Issues Losses/Moves/Big Changes Parental Drug Hx		

RELIGIOUS/SPIRITUAL/CULTURAL HISTORY: (current practices/beliefs; upbringing; sources of support and involvement)

Current Practices/Beliefs:

Upbringing:

Sources of Support and Involvement:

SUBSTANCE ABUSE QUESTIONNAIRE

Describe nicotine and caffeine use: (cigarettes, coffee, soda, energy drinks, diet pills) _____

☐ Client has no current or past use of alcohol or other drugs (***do not*** complete the remainder of the questionnaire)
☐ Client has current use or used in the last 12 months (complete items 1-15 below)
☐ Client has a history of use prior to the last 12 months (complete items 1-10 below)

Dates of use: _____

Did client seek help? (when, where, for how long) _____

	Yes	No
1. Did you use ***larger amounts of drugs*** or use them ***for a longer time*** than you planned or intended?	☐	☐
2. Did you ***try to cut down on your drug use*** but were ***unable*** to do it?	☐	☐
3. Did you ***spend a lot of time*** getting drugs, using them, or recovering from their use?	☐	☐
4. Did you ***get so high or sick*** from drugs that it –		
a. ***kept you from*** doing work, going to school, or caring for children?	☐	☐
b. ***caused an accident*** or put you or others in danger?	☐	☐
5. Did you ***spend less time at work, school, or with friends*** so that you could use drugs?	☐	☐
6. Did your drug use ***cause*** – a. ***emotional or psychological*** problems?	☐	☐
b. problems with ***family, friends, work, or police***?	☐	☐
c. ***physical health or medical*** problems?	☐	☐
7. Did you ***increase the amount*** of a drug you were taking so that you could get the same effects as before?	☐	☐
8. Did you ever keep taking a drug to ***avoid withdrawal symptoms*** or keep from ***getting sick***?	☐	☐
9. Did you ***get sick or have withdrawal symptoms*** when you quit or missed taking a drug?	☐	☐

10. Which ***drug*** caused the ***most serious problem***? [CHOOSE ONE]

☐ None
☐ Alcohol
☐ Marijuana/Hashish
☐ Hallucinogens/LSD/PCP/Psychedelics/Mushrooms
☐ Inhalants
☐ Crack/Freebase
☐ Heroin and Cocaine (mixed together as Speedball)
☐ Cocaine (by itself)
☐ Heroin (by itself)
☐ Street Methadone (non-prescription)
☐ Other Opiates/Opium/Morphine/Demerol
☐ Methamphetamines
☐ Amphetamines (other uppers)
☐ Tranquilizers/Barbiturates/Sedatives (downers)

11. How often did you use each type of drug during the ***last 12 months***?	**Drugs used in the last 12 months**				
	Never	*Only a few times*	*1-3 times a month*	*1-5 times a week*	*About every day*
a. Alcohol	☐	☐	☐	☐	☐
b. Marijuana/Hashish	☐	☐	☐	☐	☐
c. Hallucinogens/LSD/PCP/ Psychedelics/Mushrooms/Ecstasy	☐	☐	☐	☐	☐
d. Inhalants	☐	☐	☐	☐	☐
e. Crack/Freebase	☐	☐	☐	☐	☐
f. Heroin and Cocaine (mixed together as Speedball)	☐	☐	☐	☐	☐
g. Cocaine (by itself)	☐	☐	☐	☐	☐
h. Heroin (by itself)	☐	☐	☐	☐	☐
i. Street Methadone (non-prescription)	☐	☐	☐	☐	☐
j. Other Opiates/Opium/Morphine/Demerol	☐	☐	☐	☐	☐
k. Methamphetamines	☐	☐	☐	☐	☐
l. Amphetamines (other uppers)	☐	☐	☐	☐	☐
m. Tranquilizers/Barbiturates/Sedatives (downers)	☐	☐	☐	☐	☐
n. Other: (*Rx pain medication, OTC meds, specify)* _____	☐	☐	☐	☐	☐

12. During the last ***12 months***, how often did you ***inject drugs*** with a needle?
☐ *Never* ☐ *Only a few times* ☐ *1-3 times per month* ☐ *1-5 times per week* ☐ *Daily*

13. How serious do ***you*** think your ***drug problems*** are?
☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

14. How many times ***before now*** have you ever been in a ***drug treatment program***? [DO NOT INCLUDE AA/NA/CA MEETINGS]
☐ *Never* ☐ *1 time* ☐ *2 times* ☐ *3 times* ☐ *4 or more times*

15. How important is it for you to ***get drug treatment now***?
☐ *Not at all* ☐ *Slightly* ☐ *Moderately* ☐ *Considerably* ☐ *Extremely*

VIOLENCE ISSUES: (Answer all questions; add information for all "yes" answers)

☐ Yes ☐ No Current thoughts of hurting others or has made threats (within past 6 months)?

☐ Yes ☐ No History of violence toward family?

☐ Yes ☐ No History of violence toward others?

☐ Yes ☐ No History of violence toward property?

☐ Yes ☐ No History of arrests for violence?

☐ Yes ☐ No Access to weapons?

☐ Yes ☐ No Physical/sexual abuse of or by client?

☐ Yes ☐ No Family Hx of physical/sexual abuse of other family members?

☐ Yes ☐ No Family Hx of Domestic Violence?

☐ Yes ☐ No ☐Tarasoff/ ☐APS/ ☐ CPS/ ☐TRO Interventions (check which one(s) and list by history, if known)?

SELF-HARM ISSUES:

☐ Yes ☐ No Current thoughts of/attempts at harming self?

☐ Yes ☐ No History of thoughts/attempts at harming self?

SUICIDE ISSUES: (Answer all questions; add information for all "yes" answers – when, how, method, level of severity/lethality of attempt)

☐ Yes ☐ No **Current thoughts** of killing self?

☐ Yes ☐ No **History of thoughts** of killing self?

☐ Yes ☐ No History of suicide **attempt(s)**?

☐ Yes ☐ No Family Hx of suicide?

STRENGTHS and INTERESTS OF BOTH CLIENT AND FAMILY (Clinician, Client and/or Family's Assessment):

Client:

Family (1 or more members):

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Axis V: **GAF** Current: Highest in past year:

PSYCHOSOCIAL & ENVIRONMENTAL CONCERNS: (Check applicable concern and describe circumstances.)

	Describe Circumstances
☐ A. Problems with primary support group: e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home remarriage of parent; sexual or physical abuse; parental overprotection, neglect of child; inadequate discipline; discord with siblings; birth of a sibling.	
☐ B. Problems related to the social environment: e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement).	
☐ C. Educational problems: e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment.	
☐ D. Occupational problems: e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers.	
☐ E. Housing problems: e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord.	
☐ F. Economic problems: e.g., extreme poverty; inadequate finances; insufficient welfare support.	
☐ G. Problems with access to health care services: e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance.	
☐ H. Problems related to interaction with the legal system/crime: e.g., arrest; incarceration; litigation; victim of crime.	
☐ I. Other psychosocial and environmental problems: e.g., exposure to disasters; war; other hostilities; discord with non family caregivers such as counselor, social worker, or physician; unavailability of social service agencies.	

CLIENT IMPACTED IN THE FOLLOWING AREAS OF FUNCTIONING:

	How have symptoms changed functioning in given areas?	**Duration of symptoms (in months/years):**
☐ School		
☐ Home		
☐ Community		
☐ Self-care		
☐ Other:		

FAMILY OF ORIGIN INFORMATION: (Use a separate piece of paper if necessary.)

Please write about your parents…..

Please write about your siblings….

Please write about your childhood, and about your teen years….