NEW PATIENT ASSESSMENT

Patient's Name:

D.O.B: Gender: Date:

Home Address:

City: State: Zip Code:

Home Phone: Work Phone: Email:

May I contact you at home? By Mail ☐ Yes ☐ No By Phone? ☐ Yes ☐ No By Email? ☐ Yes ☐ No

May I contact you at work? ☐ Yes ☐ No

Contact In Emergency Situation:

Telephone Number: Relationship:

Social Security #: Employer:

Occupation:

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-Habitating

Partner's Name: Partner's Employer:

Insurance Provider:

Policy #: Group #:

To be completed if patient is a minor:

Parent/Guardian:

School:

What concerns/brings you to counseling?

MEDICAL HISTORY

Primary Care Physician:

Telephone Number:

Currently under a medical physician's care? ☐ Yes ☐ No

If yes, please describe your current medical condition(s):

Medications currently used: ☐ None

Medication	Dosage	Dr. Prescribing	Why Prescribed

Past Hospitalizations (i.e., Medical, Psychiatric, Chemical Dependency): ☐ None

Date(s)	Reason(s)	Hospital

Previous Counseling or Chemical Dependency Treatment/Services: ☐ None

Facility/Therapist's Name	Date of Service	Reason for Treatment	Helpful?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

CHEMICAL DEPENDENCY ASSESSMENT

Alcohol Use

Do you ever feel guilty about your drinking habits? ☐ Yes ☐ No

If yes, please describe:_____

Have you ever attempted to reduce your alcohol intake? ☐ Yes ☐ No

If so, what was the outcome?_____

Do family members/friends ever complain about your drinking behavior? ☐ Yes ☐ No

Have you lost friends or alienated family members due to your drinking behavior? ☐ Yes ☐ No

Have you ever been reprimanded at work due to your drinking behavior? ☐ Yes ☐ No

Have you ever been arrested for your drinking behavior? ☐ Yes ☐ No

Do you ever end up drinking more than you intended? ☐ Yes ☐ No

Can you stop drinking, without a struggle, after one or two drinks? ☐ Yes ☐ No

How many drinks do you need to feel a "buzz?" ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

How many drinks does it take to get drunk? ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 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) & Prescription Drugs

Do you ever use illegal drugs? ☐ Yes ☐ No

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

_____

Do you ever take prescription medication in a way that is not medically advised (i.e., taking more than prescribed or taking more often than advised)? ☐ Yes ☐ No

If yes, please list/describe:_____

_____

Do you ever feel guilty about your drug use? ☐ Yes ☐ No

If yes, please describe:_____

Have you ever attempted to reduce your drug intake? ☐ Yes ☐ No

If yes, what was the outcome?_____

Do family members/ friends ever complain about your behavior while on drugs? ☐ Yes ☐ No

Have you lost friends or alienated family members due to your behavior on drugs? ☐ Yes ☐ No

Have you ever been reprimanded at work due to your behavior while on drugs? ☐ Yes ☐ No

Have you ever been arrested for your behavior while on drugs? ☐ Yes ☐ No

Do you ever end up taking more drugs than you intended? ☐ Yes ☐ No

Can you stop taking drugs without a struggle? ☐ Yes ☐ No

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

_____

What 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. feel like harming yourself in any way?) ☐ Yes ☐ No

If yes, please describe your feelings/intent: _____

_____

Have you ever been suicidal in the past? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

Have you ever attempted suicide or to seriously harm yourself? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

Do you currently have the intent to harm, seriously hurt, or kill another individual? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

Have you ever seriously harmed, purposefully, another individual? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

Have you ever been hit, kicked, punched, or otherwise hurt by someone in the past year? ☐ Yes ☐ No

If so, by whom? _____

Please describe what happened: _____

_____

Do you feel safe in your current relationship? ☐ Yes ☐ No

If no, please describe further: _____

_____

Is there a partner from a previous relationship who is making you feel unsafe now? ☐ Yes ☐ No

If so, whom? _____

Please explain further: _____

_____

Have you ever been sexually abused? ☐ Yes ☐ No

Please explain further: _____

_____