Central Peninsula Hospital
Behavioral Health Department
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Personal Response Form – Assessment Application

Dear Prospective Client: The information that you share with us in this document is considered sensitive and will be kept confidential. It will be reviewed by your assessing counselor, along with meeting for a personal interview, in order to best understand your needs and find the right treatment fit for you. Thank you for taking your time to provide us with honest answers.

Full Legal Name: Today's Date:
Current Phone Number(s) Home: Cell:
Your Date of Birth: City/State/Country of Birth:
Current Mailing Address:
Former/Maiden Names (if any):
Current Legal Marital Status: Single Married Divorced Widowed If a Minor, Current Legal Guardian/Parent:
Social Security Number:
Preferred name that you like to be called (nickname, middle name, etc.), if any:
Who referred you to our agency?
Insurance or Payment Source: *(please circle all applicable answers):* SELF-PAY MEDICAID INSURANCE VETERAN ANMC OTHER ***If Insured:*** Primary Insurance Company Name: _____ Name of Insured:_____ Date of Birth:_____ Policy #:_____Group #_____ Secondary Insurance Company Name: _____ Name of Insured:_____ Date of Birth:_____ Policy #:_____Group #_____
Persons to Notify in Case of Emergency: Name: Address: Phone Number(s): Name: Address: Phone Number(s):

Brief description of the problem that you hope we can help you with: Brief description of the improvements that want to see in your life:

Your Social History and Current Status

Age:	
Sexual Orientation:	
Identified Gender:	
Race or Ethnic Identification	
Cultural/Ethnic Preferences or Practices, if any:	
Your Preferred Language:	
Other Languages Spoken, if any:	
Do you have any Military Service History: If yes, when?	
Do you have a specific religion or spiritual belief that is important to you?	
If yes, what religious or spiritual practices are important to you, if any?	
Leisure, Hobbies and Recreation (What do you like to do for fun?):	
Number of Pregnancies, if any:	
Number of Live Births, if any:	
Children/Minors in Your Care or Home (Currently): *provide first names and ages*	
Children/Minors Not in Your Care (Currently): *provide first names and ages*	

Are you in a romantic or committed relationship or marriage with anyone right now? If yes, tell us a little bit about this relationship (partner's name, length of time together, are you happy or unhappy). If no, how long have you been single?
Where do you live right now? How long have you been living there? Are you happy with your current living arrangement?
If you have children, what are the parenting arrangements right now? (who has custody, how is it going, etc?)

Do you have any issues related to parenting that you would like counseling help with? If yes, please briefly explain:
Have you been sexually active in the past 12 months? If yes, how many sexual partners have you had in the past year? Gender(s) of partners: Safe sex, unsafe sex, or both:
Do you have any sexual concerns or problems that you would like counseling help with? If yes, please briefly explain:
Have you had any abuse in your adult relationships? Physical: Sexual: Emotional/Verbal: Other:
Did you have any abuse or neglect in your childhood? Physical: Sexual: Emotional/Verbal: Other:
Have you ever been abusive to someone else? Physical: Sexual: Emotional/Verbal: Other:
Are there any immediate serious family problems going on right now? If yes, please briefly explain:
Have you lost anyone in your family (or close friends) due to death or suicide? When?
Current Financial Status: Have you worked in this past year? What was your yearly income this past year? How much money do you make right now, monthly? Are you able to meet your basic needs? Do you have any other sources of financial support/help? *(Food stamps, family, unemployment, child support, etc)* What are your main financial concerns right now?

Who are your friends right now, if any? What are they like? Are they supportive of your desire to enter treatment or get counseling? Describe: Please provide names of supportive family members, if any: Do you have any family members or close friends that you would like to be part of the counseling or treatment process? Please provide names, if so: Do you have any family members or friends that you do NOT want to be involved right now: Please provide names, if so:
Share some of your personal strengths, talents, and abilities:
What are some of the biggest obstacles or challenges that might stand in the way of your success?

Developmental History

*History from your childhood and teenage years **(ages 0-18)***

Did you have normal physical development as a child, or were there any delays (such as in walking, talking, or puberty):	
Do you feel like your emotional development was normal or were there areas that you struggled with?	
Were you able to make friends as a child or was it difficult for you?	
Did you behave and follow rules normally, or was it difficult for you to follow rules at school or at home?	
Were you able to learn at a normal rate, or were there any learning disabilities or challenges?	
Did you have any problems with speech, hearing, or vision? Please describe, if yes:	
Did you have enough to eat when you were a child? Would you say that your average meal was healthy and nutritious, poor nutrition, or a mixture?	
Is there any possibility that your mother might have used alcohol or drugs when she was pregnant with you? Did anyone ever tell you that you had FASD?	
Did you ever have an injury to your brain or get knocked unconscious as a child? If yes, did it cause any problems for you after?	

Biophysical and Medical: Current Status and History

Your Past Medical History (surgeries, major medical problems or issues):
Your Medical Health Conditions right now:
Who is your usual medical provider?
How often do you see a medical provider? How many times have you been to the Emergency Room in the past 12 months?
Are there any medical concerns right now that you haven't seen a doctor about?
When was your last Physical Exam: Findings of last physical exam:
What is your biological family's health history *(such as cancer, diabetes, heart problems, blood pressure, etc):*
What is your family's attitude towards getting medical care?
Current Prescription Medicines that you are taking: Do you take any vitamins or supplements? If yes, what? Do you have any allergies to any medications? If so, what? **Allergies**: any other non-food allergies *(such as bees, detergent , latex, etc)?* If so, describe: What do you do if you have a reaction?
Nutritional/Diet: Have you had any significant weight gain or loss in the past couple months? Describe: Do you have any food allergies? If yes, describe: Do you have any special diet needs (diabetic, religious, vegan?)? If yes, please describe how you manage this: Do you have a nutritionist, dietician, or person that you work with on food related issues? Do you have any problems with eating, such as binging, or restricting calories? If yes, please describe: Would you like any help with food related issues while you are in counseling?

Physical Pain:
Are you currently in pain?
On a scale of 0-10 (0 none, 10 unbearable), please rate your pain today:
If yes, where is the location of the pain?
What makes the pain worse?
What makes the pain better?
Are you seeing someone for pain?
If yes, please describe who and what the treatment is:

Physical Activity:
How physically active are you right now?
What kind of physical shape would you like to be in?
Do you have any restrictions or disabilities that keep you from participating in certain physical fitness activities? If yes, please describe:

Do you have any goals for your physical health?

Sexual Health:
Birth Control used:
Date of Last Pelvic Exam:
Would you like to be tested for sexually transmitted infections while you are in treatment?

Dental/Oral Health:
How often do you see a dentist?
Regular dental provider:
Date of last Dental Exam:
Do you have any dental concerns or needs right now? If yes, please describe:

Withdrawal Symptoms:
If you are addicted to drugs or alcohol, what are your typical withdrawal symptoms:

If you are entering treatment with us soon, what withdrawal symptoms do you expect to have?
How do you typically manage these?

How would you describe the quality of your sleep in this past month:

Would you like help on learning good sleep practices?

Do you use nicotine?
If yes, please describe how (cigarettes, vape, chewing tobacco, etc.):

How much do you use each day?

Have you ever had a brain injury, concussion?
Were there any changes in your thinking or personality after the brain injury?

Did your mother consume alcohol or drugs while she was pregnant with you?
Were you ever diagnosed with FASD?

Any Additional Health Comments or Concerns:

Educational and Vocational Status and History

What is the highest grade you have completed in school?
What was school like for you, overall?
Did you have any learning disorders or problems with learning? If yes, please describe:
What is the best way for you to learn things *(visual, audio, hands-on, etc):*
What were your favorite classes or subjects:
Did you care about doing well in school?
Do you have any interest in going on in school or college? If yes, describe:
Have you had any vocational training or attended a trade school *(electrical, construction, welding, chef, beautician, medical coding, etc)*.? If yes, describe:
Do you have any interest in furthering your vocational training? If yes, describe:
Current Employer/Employment: How long have you been at this job?
Brief Work History:
What are your long-term career goals, if any?
What are your immediate employment needs, if any?

Legal Status and History

Number of Arrests in Past 12 Months:	
Total amount of lifetime spent in jail or incarcerated:	
Legal issues in Past 12 Months: What is your present legal status? Probation Officer (if on probation):	
Do you have OCS involvement? If yes, provide name of OCS caseworker:	
Current/Pending Future Court Date? If yes, provide date:	
Do you have an attorney? If yes, provide name:	
Please briefly describe your legal history:	

Mental Health Status and History

Have you ever been to counseling for help with your mental help? Briefly explain, if so:	
Have you ever been hospitalized for your mental health? Briefly explain, if so:	

Have you ever been given a mental health diagnosis? If so, please describe:	
If you have had counseling or mental health services, did you find them helpful? Please briefly explain:	
Please describe what your daily mental health (thoughts, emotions, etc) is like right now:	
Depression symptoms can sometimes include feelings of hopelessness, problems with sleep, low self-worth, low energy, low motivation, and more. If you are experiencing some depression, please describe your symptoms:	
Anxiety symptoms can sometimes include feeling afraid, irritable, panicky, nervous, having, problems with sleep, problems concentrating, and more. If you are experiencing some anxiety, please describe your symptoms.	
When you feel emotionally overwhelmed, how do you cope?	
Have you ever self-harmed? Do you currently self-harm? Please briefly explain:	
Have you ever tried to end your life? If yes, please briefly explain: Are you currently feeling suicidal? If you feel suicidal, do you have a plan? Please briefly describe:	
Do you hear voices? Do you hear or see things that other people say aren't there?	
Have you ever been diagnosed with ADD or ADHD? Do you have problems paying attention? Do you have problems sitting still?	
Do you have problems controlling your temper when you get angry? Have you ever hurt someone or damaged property because you were angry? Please briefly explain:	
Do you have big mood swings up and down (over a short or long period of time)? Do you have periods of time where you feel like you are on top of the world, spend too much money, feel very sexual, talk really fast or need hardly any sleep? Please briefly explain, if so:	

Do you have any obsessive or compulsive behaviors? *(handwashing, skin picking, persistent urges or thoughts, etc)* Do you have any addictions to non-drug-related things (*sex, gambling, video games, etc)*?	
Do you binge on food sometimes (eating more than you wanted to and then feeling bad about it later)? Do you restrict food or calories in a way that others say is too excessive? If you struggle with food-related issues, what are your beliefs about food? If you have any concerns about food-related behaviors, please explain:	
Do you have any grief or loss about the death of loved one(s) or changes in your life or family structure? Please explain: Do you have a past history of trauma or abuse that you hope counseling will help you with? Briefly explain:	
Do you think that counseling will be able to help? Please explain:	
Do you have any mental health issues in your biological family *(include schizophrenia, bipolar disorder, ADHD, depression, anxiety, PTSD, mental health hospitalizations, etc):* How does your family feel about people who go to counseling?	
What is something that you hope will get better within a month of starting counseling?	
What is something that you hope will get better within a year of starting counseling?	

***Substance Use: Current Status and History**

*After each item, please share how old you were when you **started** using it, the date you **last** used, how **much** you typically used, and **how** you used it (smoke, snort, IV, drink):*

Alcohol:	
Heroin:	
Other Opiates/Pills:	
Methamphetamine:	
Amphetamines/Speed:	
Cocaine/Crack:	
Xanax/Anxiolytics/Benzos:	
MDMA/Molly/Ecstasy:	
Cannabis/Marijuana:	
Spice:	
Bath Salts/Designer Drugs:	
Inhalants:	

Hallucinogens/LSD:	
Other:	

**If you have no alcohol or drug use, or no addiction, mark Not Applicable on any current addiction questions*

***Please Briefly Describe the Consequences that Addiction has in these Areas:**

Intimate Relationships/Marriage:

Family/Children:

Employment/Educational:

Social/Friends/Community:

Emotional:

Physical/Body:

Legal:

Have you ever had treatment for alcohol or drug use before?
If yes, please describe when and where:

In what ways was it helpful?

Have you tried 12 step meetings before?
If yes, how often do you attend meetings right now?

If you have tried to quit drugs or alcohol on your own, please briefly describe how often you have tried and what the results were:

Does your biological family have any problems with drugs or alcohol use?
Please describe:

Have any family members ever gone to treatment, rehab, or addiction counseling?

What is your family's view of you entering addiction treatment?

Where are you at, in terms of your motivation to make changes?
Circle the best answer:

I'm not really sure if change is even possible for me.
I'm thinking about changing…but I will need some help to actually do it.
I'm starting to take some steps towards making changes, but I could use some help.
I'm already taking active steps towards change and it's going well.
I've made a complete change and it's been working really well for months!

Please share what *immediate* changes you hope will happen as a result of getting into addiction treatment:

Please share what long-term changes you hope will happen for you as a result of getting into addiction treatment:

Thank you so much for your thoughtful and honest answers!

Family Involvement Questionnaire

The following questions are wonderful things to ask an involved family member or close friend. You can have them fill this part out, or you can talk to them and write down their answers yourself. (If you don't have an involved person right now, that's okay. Write "not right now" below).

Family Member/Guardian/Friend's Name:

Family/Guardian/Friend's Contact Phone Number:

Family/Friend's perception of the individual's strengths, talents, and abilities:

Family/Friend's Comments or Concerns about Individual's Current Problem or Issue:

Additional thoughts or comments:

Services that the Family/Friend Wants for the Individual
(Please circle the service that you think will best fit your loved one's immediate needs):

- Intensive Residential Treatment (for at least 1-2 months)
- Long-term residential Treatment (over 3 months, up to 1 year)
- Intensive Outpatient Treatment (1-4 hours daily attendance, M-F)
- Outpatient Treatment (2-6 hours per week)
- Individual Counseling Only (1x per week or less)
- Family/Couples Counseling Only (1x per week or less)
- Other:

What is *your* desired involvement level in your loved one's treatment or services:

- I want to come to Family Day Group at Residential Treatment every week (1x per week)
- I want to be involved in some kind of counseling services on a weekly or bi-weekly basis
- I would like to check in regularly, once every month or two, with the counselor
- I want to be supportive but I don't need to be a part of the counseling process
- I want to be a part of the counseling process if there is an emergency
- Other:

Family/Friend, thank you for your help completing this part of the application packet!