Welcome to Bear River Mental Health Services, Inc. As an important part of your assessment appointment, we ask that you fill out the following information packet as completely as possible. Completion of this packet will greatly assist your therapist in becoming familiar with your history. This will help our therapist develop a treatment plan and focus more on understanding your principle concerns. This information is kept confidential, except for special legal cases. No one outside of the Center may see your records without your written permission. If you have questions or concerns, please contact our service coordination staff at the appropriate location.

Cache and Rich Counties: 435-752-0750

Brigham City: 435-734-9449

Tremonton Area: 435-257-2168

CONFIDENTIAL MATERIAL

WILL NOT BE RELEASED WITHOUT WRITTEN PERMISSION

ADULT PERSONAL HISTORY

Client Legal Name _____ **Date** _____

Client Preferred Name _____ **Client Preferred Pronoun** _____

PRESENTING PROBLEMS

Please list the problems or difficulties for which you are seeking help. Begin with the problem that is bothering you most.

1. _____
   Rate the severity of problem #1 ___mild ___ moderate ___severe Length of problem _____

2. _____
   Rate the severity of problem #2 ___mild ___ moderate ___severe Length of problem _____

What solutions have you already tried to correct the main problem? _____

_____

What do you hope to achieve by seeking services here? _____

What are the current stressors/difficulties in your life?

____ your health	____ housing	____ communicating with others	____ safety
____ managing time	____ finances	____ eating/drinking habits	____ solving problems
____ family	____ alcohol/drug use	____ leisure time	____ getting help
____ friends	____ sex life	____ being productive	____ coping
____ rules/behavior	____ cleanliness	____ self-care	____ dress/appearance

____ other, please list: _____

CURRENT AND PAST SYMPTOMS

Please rate yourself on the following symptoms:

	Never	Almost Never (ie. 1 day a week)	Some of the time (ie. 2-3 days)	Most of the time (ie. 4-5 days)	Almost all the time (ie. 6-7 days)
Appetite problems	○	○	○	○	○
Sleep problems	○	○	○	○	○
Weight gain or loss	○	○	○	○	○
Loss of interest in things	○	○	○	○	○
Problems concentrating	○	○	○	○	○
Guilt	○	○	○	○	○
Low self-worth	○	○	○	○	○

	Never	Almost Never (ie. 1 day a week)	Some of the time (ie. 2-3 days)	Most of the time (ie. 4-5 days)	Almost all the time (ie. 6-7 days)
Hopelessness	○	○	○	○	○
Suicide thoughts	○	○	○	○	○
Explosive anger	○	○	○	○	○
Irritability	○	○	○	○	○
Anxiety and Stress	○	○	○	○	○
Mood swings	○	○	○	○	○
Hearing voices	○	○	○	○	○
Nightmares	○	○	○	○	○
Other, please list: _____	○	○	○	○	○

Length of your symptoms (consecutive months): ___0-1months ___2-5mths___6-12mths ___12+mths___2 yrs.+

ALCOHOL or DRUG or SUBSTANCE USE

Do you drink alcohol? ___Never ___Rarely ___Sometimes ___Almost daily

If yes, what do you normally drink? _____

Do you now (or in the past) use tobacco or nicotine? ___ Yes ___ No If yes, please explain:_____

_____

Do you currently use any street drugs? ___Never ___Rarely ___Sometimes ___Almost daily

If yes, what kind? _____

Do you take any medications that are not prescribed to **you**? ___Never ___Rarely___Sometimes ___Almost daily

If yes, what kind? _____

Do you ever take prescription medication more frequently than prescribed? ___No ___Yes

If yes, please explain:_____

Have you used drugs in the past —what type and when? _____

_____

Have drugs or alcohol ever contributed to any problems in your life? ___ Yes ___ No If yes, when? _____

_____

Have you ever received formal treatment for substance abuse?

When and Where? _____

Treatment focused on what substance? _____

Was the treatment inpatient/residential ___ outpatient ___ or both ___?

Have you ever been involved in a twelve-step group? (AA, NA, etc.) ____Yes ____No

CHILDHOOD FAMILY AND DEVELOPMENTAL HISTORY

Where were you born and raised? _____

Were there any problems with your birth or development in early childhood—ie. slow to walk or talk, significant childhood illnesses, problems learning ?_____

Father's Name _____ Occupation _____

Divorced ___No ___Yes If yes, date _____ Deceased ___No ___Yes If yes, date _____

How would you describe your father? _____

Mother's Name _____ Occupation _____

Divorced ___No ___Yes If yes, date _____ Deceased ___No ___Yes If yes, date _____

How would you describe your mother? _____

Step-father's Name _____ Occupation _____

Divorced ___No ___Yes If yes, date _____ Deceased ___No ___Yes If yes, date _____

How would you describe your stepfather? _____

Step-mother's Name _____ Occupation _____

Divorced ___No ___Yes If yes, date _____ Deceased ___No ___Yes If yes, date _____

How would you describe your stepmother? _____

List your brothers and sisters, <u>from oldest to youngest</u>, including yourself, and show whether your relationship with each brother or sister has been negative or positive by circling the (+) for positive or the (-) for negative.

Sibling Relationships				
Brother or Sister	Age	Sex	Relationship Growing Up	Relationship Right Now
			+ -	+ -
			+ -	+ -
			+ -	+ -
			+ -	+ -
			+ -	+ -
			+ -	+ -

What are the most pleasant memories from your youth? _____

_____

What are the unhappiest things you experienced growing up? _____

_____

Please list any separations from your parents / care givers you may have experienced as a child (ie. placed in foster care, moved from family member to family member, incarceration of parent, death of a parent etc.): _____

_____

Were there any problems in your family during your childhood regarding any of the following?

Check if any apply. discipline ___ communication ___ showing love ___

Explain:_____

_____

_____

MARITAL / RELATIONSHIPS

(A life partner is defined as someone whom you are living with in a committed relationship)

Marriages/Relationships			
	First	Second	Third
Name of spouse or life partner			
Partner's occupation			
Your age at time of marriage			
Partner's age at time of marriage			
Length of marriage in years			
Number of children by marriage			
If marriage has ended, was it by death or divorce?			
Year of death or divorce			

Overall, how would you describe your present relationship with your spouse or partner?

___Excellent ___Good ___Average ___Fair ___Poor

Describe your present partner's strengths _____

Describe his or her weaknesses _____

Are there problems in your present relationship? (specify) _____

_____

List your children, if any, from oldest to youngest and indicate whether your relationship with each is positive by circling (+) or negative by circling (-).

Relationships with Your Child/Children					
Child	Age	Sex	Relationship Growing Up	Relationship Right Now	Living in Home
			+ -	+ -	___ Yes ___ No
			+ -	+ -	___ Yes ___ No
			+ -	+ -	___ Yes ___ No
			+ -	+ -	___ Yes ___ No
			+ -	+ -	___ Yes ___ No
			+ -	+ -	___ Yes ___ No
			+ -	+ -	___ Yes ___ No

Describe any specific parenting concerns: _____

_____

Describe any other family concerns: _____

_____

What is your present living situation?

_____ Renting _____ Living in house you own
_____ Living with family _____ Living with friends
_____ Other (specify) _____

Would you say that this situation is stable for the next 3-6 months? _____

How long have you lived in the county you reside in? _____

Where did you live previously? _____ Length of time there? _____

What are your present interests, hobbies, and leisure time activities? _____

_____

How often do you do social activities outside of work or school with other adults? Check the one that best applies: ___ Rarely ___ 1x month ___ 2-3x month ___ 1x week ___ 2x week +

Do you have relatives or close friends in whom you can confide? ___ Yes ___ No

Who? _____

How many close friends do you now have? _____

What would you say are your greatest personal strengths or skills? _____

_____

MEDICAL HISTORY

Personal physician's name _____

Date of last physical examination _____

Specialist(s) you are presently seeing _____

List any medications you have taken regularly, either in the past or present					
Name of Drug	Dosage	Frequency	Prescribing Physician	Date Started	Date Discontinued

Are you allergic to any medications, food, or inhalants? ___No ___Yes

If yes, list them _____

List any operations (including dates--to your best recall) _____

_____

Please indicate with a check whether you or a family member have had any of the following:

Condition	**You, in the past 3 months**	**You, more than 3 months ago**	**Family member**
Severe headaches			
Convulsions or seizures			
Asthma			
Colitis			
High blood pressure			
Heart problems			
Cancer			
Diabetes			
Hypoglycemia			

Ulcers			
Premenstrual tension			
Thyroid problems			

Do you have any other current medical problems? _____

Have you ever had a head injury where you lost consciousness? ___ No ___ Yes If yes, please describe the circumstances: _____

Do you suffer from chronic pain? ___No ___Yes How long have you had this problem? _____

What is the site of your pain? _____

ABUSE / TRAUMA HISTORY

Were you ever abused as a child? ___No ___Yes

Emotional abuse ___No ___Yes If yes, by whom? _____

Physical abuse ___No ___Yes If yes, by whom? _____

Sexual abuse ___No ___Yes Family member ___Yes ___No ___Uncertain

Have you ever been the victim of abuse as an adult? ___ No ___ Yes, physically ___ emotionally___ sexually

Explain: _____

Have you ever been involved in any other type of traumatic incidents such as Medical Trauma, Natural Disasters, Refugee Trauma, Terrorism, Victim of a Crime, or Traumatic Grief? ○ No ○ Yes

Explain: _____

CULTURAL / ETHNIC INFORMATION

Please list (describe) any information about yourself, your life, or your family that is unique to you that would be helpful for your therapist to be aware of, i.e. religious views/beliefs, family heritage, family traditions, cultural beliefs:

_____

_____

_____

_____

EDUCATIONAL HISTORY

Do you have any behavior or attention problems in school? ___ Yes ___ No

Is there any family history of the same problems? If so, who? _____

Did you ever participate in resource classes? ___Yes ___No If yes, which areas did you have difficulty with?

___reading ___math ___writing ___science ___social studies

What is your highest level of education? **Please circle**: High school 9, 10, 11, 12

Vocational or technology school 1, 2, 3 College 1, 2, 3, 4 Graduate school 1, 2, 3, 4, 5

Degrees, certifications, or vocational licenses _____

Major field of study in college or vocational school _____

OCCUPATIONAL HISTORY

Do you currently consider yourself able to work? _____ If not, what situation or condition prevents you from doing so? _____

How many jobs have you had in the past five years? _____

What is your present occupation? (If homemaker or student, please indicate) _____

How long have you worked at your present job? _____

How would you rate your present job? ___ Excellent ___ Good ___ Average ___ Fair ___ Poor

HISTORY OF MENTAL HEALTH TREATMENT

Have you been treated or hospitalized for mental or emotional problems in the past? ___No ___Yes
If yes, please describe below:

Where	When	Condition / Diagnosis treated	Doctor / Therapist

Does anyone else in your family have a history of mental illness? ___No ___Yes
If yes, please explain:_____

_____

PERSONAL SAFETY

Have you ever been suicidal?

___Never
___Yes, I've wished I was dead or wouldn't wake up.
___Yes, I've had thoughts of killing myself but never made a plan.
___Yes, I have thought about a plan.
___Yes, I am feeling suicidal now.
___Yes, I have attempted suicide in the past. Please describe how and when:_____

_____

Have you had any thoughts of hurting others recently? ___No ___Yes.

Do you have a history of assault? ___No ___Yes If yes, please explain. _____

Have you ever been arrested or charged with a crime? ___No ___Yes If yes, explain:

_____

Have you served time in jail? ___No ___Yes Served time in prison? ___No ___Yes___

Are you currently on probation or parole? ___No ___Yes Probation Officer_____

_____ _____

Signature of client **Date**