Eastside Center for Family

INTAKE & DIAGNOSTIC ASSESSMENT

PLEASE PRINT

Date of Evaluation _____ Patient Email _____

Name _____ Home Phone ( ) _____
First Middle Last Nickname

Address _____ Work Phone ( ) _____
Street • PO Box Apartment

_____ Date of Birth _____
City State ZIP Code Month • Day • Year

Drivers License or ID# _____ State _____ Age _____

Social Security Number ___–___–_____ Height _____ Weight _____ Gender ☐ M ☐ F

Personal Physician _____ Phone ( ) _____
Name Address City

Preferred Hospital _____
Name Address City

Emergency Contact _____ Phone ( ) _____
Name Relationship City

Preferred Contact _____ Phone ( ) _____
Name Relationship City

Ever been a patient here before? ☐ Yes ☐ No If Yes, when? _____

How did you learn about us?
(check the one that influenced your decision the most)

- ☐ Attorney / Court / Probation
- ☐ Chemical Dependency Agency / Detox
- ☐ Physician or Hospital
- ☐ Insurance Company / Managed Care
- ☐ Employer / EAP / Union
- ☐ School
- ☐ Mental Health Counselor
- ☐ Native American Tribe
- ☐ Other
- ☐ Yellow Pages
- ☐ Family Member
- ☐ Friend
- ☐ From a Former Patient / Alumni
- ☐ Re-Admit / Relapse

If you checked a box
in the first two columns,
please write the name: _____

What is the problem or reason that brought you here? _____

_____

_____

What special needs or concerns should the staff be aware of for your visit today? _____

_____

_____

Continue on next page ➡

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What is the impact of the problem on your life? _____

Why does this problem continue in your life? _____

What have you tried to address the problem? _____

Ideally, what would you like to happen? _____

What do you think might bring about this preferred solution? _____

What do you think supports or inhibits this solution? _____

What are you willing to do to find a solution? _____

What do you want from us? _____

What are the next steps we need to take? _____

Continue on next page →

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PATIENT NAME _____

EDUCATION

Years of Education (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 or more

Level Completed ☐ None ☐ GED ☐ HS Diploma ☐ Vocational ☐ Associate ☐ BA/BS ☐ Masters ☐ Doctorate

How do you rate your English reading / writing skills?
☐ Good
☐ Fair
☐ Poor

Have you ever had a learning disability or been placed in a special education class?
☐ Yes ☐ No If yes, explain _____

FINANCIAL

Financial Status
☐ Good
☐ Fair
☐ Poor

Housing
☐ Rent
☐ Own
☐ Other _____

Monthly Payment $ _____

Combined Family Monthly Income $ _____

Healthcare Reimbursement Information

☐ Insurance
☐ Private Pay
☐ Medicare
☐ CHAMPUS
☐ Title XIX
☐ Agency Funded
☐ Other

Insurance Company Name _____
Phone _____
Group Number _____
Subscriber Number _____
Subscriber Name _____

FAMILY

Marital Status	Since	Number of Times
☐ Single (Never Married)		
☐ Married	_____	_____
☐ Separated	_____	_____
☐ Divorced	_____	_____
☐ Widowed	_____	_____

Who are you currently living with? _____
Name and Relationship

Does the person you are now living with:
Drink or Use? ☐ Yes ☐ No
Drink or Use to Excess? ☐ Yes ☐ No
Drink or Use in the Residence? ☐ Yes ☐ No

Number of Brothers _____
Number of Sisters _____
Your Birth Order? _____ 1st, 2nd, etc.

Birthplace _____

Placed raised _____

Years in this state _____

Children

Gender	Age	Person Living With

Write additional children on the back of this page

Check the one that is closest to your race/ethnicity:

☐ White/European American
☐ Black/African American
☐ Native American
☐ Eskimo/Alaskan Native
☐ Aleut
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Korean
☐ Vietnamese
☐ Japanese
☐ Samoan
☐ Asian Indian
☐ Guamanian
☐ Cambodian
☐ Laotian
☐ Thai
☐ Other Asian/Pacific Islander
☐ Other race
☐ Refused to answer

- If Native American/Eskimo/Alaska Native/Aleut, please provide tribal information:

Tribe or corporation _____

Tribal recognition ☐ Federal ☐ Non-Federal ☐ Canadian

Eligible for enrollment? ☐ Yes ☐ No

Enrollment number _____

Blood degree ☐ Less than ¼ ☐ ¼ or more

Check the one that is closest to your Spanish/Hispanic origin:
☐ Not Spanish/Hispanic ☐ Mexican ☐ Other Spanish/Hispanic
☐ Puerto Rican ☐ Cuban ☐ Refused to answer

Continue on next page

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PATIENT NAME _____

VETERAN STATUS

	Yes	No						
Military Service?	☐	☐	Branch _____	From _____	To _____	Highest Rate/Rank _____		
Honorable Discharge?	☐	☐	Drink/Use In Service ☐ Yes ☐ No		Demotions ☐ Yes ☐ No			
Combat Service?	☐	☐	Combat Location _____					
PTSD Diagnosed?	☐	☐	If YES, where and when diagnosed _____					
Prior PTSD treatment?	☐	☐	If YES, where and when treated _____					
Eligible for VA Benefits?	☐	☐						

LEGAL

Current Legal Problem _____ Date of Offense _____ BAL _____

Court _____ Judge _____ Case # _____

Court _____ Judge _____ Case # _____

Next Court Date _____ Case Status _____

Attorney Name _____ Phone ( ) _____

Address _____

Probation Officer _____ Phone ( ) _____

Do you have your Driving Record available today? ☐ Yes ☐ No ☐ Not Applicable

Outstanding Warrants? ☐ Yes ☐ No What & When _____

Past Arrests or Convictions

Charge	Date	Court	Final Outcome	BAL

EMPLOYMENT

☐ Employed Full-Time
☐ Employed Part-Time
☐ Self-Employed
☐ Military
☐ Student
☐ Homemaker
☐ Retired
☐ Disabled
☐ Welfare
☐ Unemployed (Seeking work)
☐ Unemployed (NOT seeking work)

Employer _____ Location _____

Length In Current Employment _____ Monthly Income $ _____

Position & Type of Work _____

Number of Employers In Past Five Years _____ Longest Time With One Employer _____

If Unemployed, What Is Your Source of Income _____

Do You Enjoy Your Job? ☐ Yes ☐ No Is your job seasonal? ☐ Yes ☐ No

Continue on next page ➡

MEDICAL

How is your overall health now? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Are you pregnant? ☐ Yes ☐ No

What physical problems do you now have? _____

Are you currently under a doctor's care? ☐ Yes ☐ No Why? _____

When was your last physical exam? _____

What medications are you now taking? _____

_____

What medications have you taken in the last 6 months? _____

What over-the-counter products (aspirin, cough medicine, etc.) are you now using? _____

Are you allergic to any medications? _____

Have you or anyone in your family ever had or been diagnosed as having any of the following?
(Check NONE for questions that do not apply)

You	Family	None		You	Family	None	
☐	☐	☐	Alcoholism	☐	☐	☐	High Blood Pressure
☐	☐	☐	Anemia	☐	☐	☐	Loss of Appetite
☐	☐	☐	Asthma	☐	☐	☐	Morning nausea, vomiting
☐	☐	☐	Cirrhosis	☐	☐	☐	Night Sweats
☐	☐	☐	Diabetes	☐	☐	☐	Numbness in fingers or toes
☐	☐	☐	Drug Addiction	☐	☐	☐	Pancreatitis
☐	☐	☐	DT's	☐	☐	☐	Recurrent diarrhea
☐	☐	☐	Fainting	☐	☐	☐	Seizures
☐	☐	☐	Fatty Liver	☐	☐	☐	Shaking
☐	☐	☐	Esophageal Reflux	☐	☐	☐	Significant weight loss or gain
☐	☐	☐	Head Injury	☐	☐	☐	TB
☐	☐	☐	Headache or Migraine	☐	☐	☐	Ulcers
☐	☐	☐	Heart Problems	☐	☐	☐	Use of Antabuse or Trexan
☐	☐	☐	Heartburn or gastritis	☐	☐	☐	Use of prescription drugs
☐	☐	☐	Hepatitis				

How many times in the past five years have you been hospitalized? _____ When? _____

Reason? _____

How many times in the past five years have you used Emergency Room services? _____ When? _____

Reason? _____

How many days in the past five years have you used sick leave (all employers)? _____ When? _____

Reason? _____

		Yes	No
Have you ever:	Had any fractures or dislocations to your bones or joints?	☐	☐
	Been injured in a traffic accident?	☐	☐
	Injured your head?	☐	☐
	Been injured in an assault or fight (not sports injuries)?	☐	☐
	Been injured while drinking?	☐	☐

Continue on next page ➡

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PATIENT NAME _____

MENTAL HEALTH

Are you currently receiving services at a mental health center or seeing a private practitioner? ☐Yes ☐ No

If yes, where and when _____

Have you ever received mental health counseling or psychiatric treatment? ☐Yes ☐ No

If yes, where and when _____

Are you currently using medications for mental health reasons? ☐Yes ☐ No

If yes, what _____

Is there a family history of mental illness? ☐Yes ☐ No

If yes, explain _____

Have you had a significant period (not the direct result of alcohol/drug use) where you experienced any of the following:

☐ Anxiousness
☐ Sleep Disturbances
☐ Phobias/paranoia/delusions
☐ Anorexia
☐ Bulimia
☐ Hallucinations
☐ Serious depression
☐ Hostility/violence
☐ Referral to mental health
☐ Grief and loss issues
☐ Inability to comprehend
☐ Loss of appetite

Have you ever attempted suicide? ☐Yes ☐ No

If yes, when and where _____

Do you have suicidal thoughts? ☐Yes ☐ No

If yes, most recent thoughts _____

Is there a family history of suicide? ☐Yes ☐ No

If yes, explain _____

Do you have a plan or have a history of self-harm (cutting, burning, scratching? ☐ Yes ☐ No

If yes, describe _____

Are you experiencing any of the following:

☐ Hopelessness
☐ Decreased energy
☐ Giving away valuable possessions
☐ Moodiness
☐ Preoccupation with death
☐ Sleeplessness
☐ Feeling withdrawn
☐ Self-destructive thoughts
☐ Taking unnecessary risks

Is there any kind of physical, emotional or sexual abuse where you live? ☐Yes ☐ No

Are you at risk of being abused? ☐Yes ☐ No

Have you ever been abused physically, emotionally or sexually? ☐Yes ☐ No

Do you have a history of violence toward others? ☐Yes ☐ No

If yes to any of the above, explain _____

Continue on next page

ALCOHOL & OTHER DRUG USE HISTORY

At what time in your life did you drink the most? From age _____ to age _____

At what time in your life did you use other drugs the most? From age _____ to age _____

Chemical assessed:_____DSM5:_____mild, moderate or severe (use separate copy of pg 6 for ea. drug)
In a 12 month period, check all that apply to you:

_____Recurring substance use has led to your failing to fulfill major responsibilities at school, work or home.
_____You repeatedly use drugs or alcohol in risky situations, such as when operating machinery or driving a car.
_____You experience alcohol or drug cravings.
_____You continue to use alcohol or drugs despite the fact that you realize that your use of alcohol or drugs causes or worsens reoccurring social or relationship problems (it keeps getting you into fights with your wife, for example).
_____You have developed a drug or alcohol tolerance. You need more than you used to experience the same effects.
_____You experience withdrawal symptoms when you stop using or significantly cut down your use, or - you use other similar substances to stave off withdrawal symptoms (for example, using Valium when not drinking).
_____You often take/drink more drugs or alcohol than you had planned on - and/or you use/drink for longer than you had planned on (for example, you often stop for a drink after work with friends and intend to have just one or two - and then you don't leave until closing time.)
_____You have a persistent desire to cut down or stop your use of drugs or alcohol, or - you have tried and failed to cut down or stop your use of drugs or alcohol.
_____You tend to spend a lot of your time using drugs or alcohol, recovering from your use of drugs or alcohol or doing what's needed to get drugs or alcohol.
_____You have given up or reduced your participation in social, occupational or recreational activities that used to be important to you, and replaced these activities with drug or alcohol use.
_____You continue to use drugs or alcohol despite knowing that drugs or alcohol cause or worsen a persistent physical or mental health problem

Please complete the table below. List all substances (including alcohol and prescription medication you have used).

Drugs Used	**Additional Drug Information** (Valium, crack, meth, etc.)	**Age at First Use**	**Age When Regular Use Began**	**Average Number of Times Used Each Week**	**Average Amount Used Each Time**	**Usual Way Used** (Oral, Smoked, Snorted, IM or IV)	**Date of Last Use**
Beer							
Wine							
Liquor							
Nicotine							
Marijuana							
Cocaine							
Caffeine							
Amphetamines							
Tranquilizers							
Opiates							
Barbiturates							
Inhalants							
Hallucinogens							
Other Drug							

Were any of the above drugs you used prescribed by a doctor or dentist? ☐Yes ☐ No

Continue on next page ➡

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PATIENT NAME_____

ALCOHOL & OTHER DRUG USE HISTORY

Has anyone in your immediate family had any problems with alcohol or other drugs? (children, parents, brothers and sisters, grandparents, uncles and aunts, cousins) ☐Yes ☐No

Who? _____

Have you ever received education or treatment for alcoholism or drug addiction? ☐ Yes ☐ No

If you have, when and where, and did you complete? _____

_____

Have you ever attended a meeting of Alcoholics Anonymous or Narcotics Anonymous? ☐Yes ☐No

If you have, when? _____

What is the longest period of time you have gone without drinking or drugging? _____

When? _____ Why? _____

When did you return to drinking or using? _____

Why? _____

Do you think you have a problem with alcohol or other drugs? ☐ Yes ☐ No Why? / Why Not? _____

_____

_____

_____

What are your typical daily activities? _____

_____

Describe your childhood religious or spiritual upbringing, traditions or experiences _____

_____

Describe the religious preferences or spiritual practices and beliefs you have now _____

_____

Please return this questionnaire to a staff member as directed