Sample Form

ASSESSMENT INFORMATION

DATE _____ AGE _____

NAME _____

CURRENTLY INCARCERATED ____NO ____YES, SINCE _____

ANTICIPATED RELEASE DATE _____

BOND SET / POSTED _____ _____BAC

***PRESENTING PROBLEM**
(date of arrest, charge, date of sentencing, ***client version of events**)

***PRIOR AND PENDING ARRESTS, CONVICTIONS, DEFERRED PROSECUTIONS** (juvenile/adult charges, original charge if plea, BAC, ***current legal status**)

***FAMILY HISTORY & ENVIRONMENTAL SETTING**
CURRENTLY MARRIED_____ DIVORCED_____
NEVER MARRIED _____ WIDOWED _____

CURRENT RELATIONSHIP: NAME _____

LENGTH / TYPE OF RELATIONSHIP _____

CHILDREN WITH THIS PERSON (names, ages, who they live with)

PRIOR MARRIAGES / SIGNIFICANT OTHER RELATIONSHIPS:
(name, duration, any children—ages)

PARENTS ARE: MARRIED_____ DIVORCED_____

SEPARATED _____ NEVER MARRIED____

CLIENT ADOPTED_____

SOCIO-ECONOMIC STATUS GROWING UP _____

FATHER—LIVING YES_____ NO_____
DATE AND CAUSE OF DEATH:

RELATIONSHIP WITH FATHER—PAST/PRESENT:

STAFF COMMENTS

MOTHER—LIVING YES_____ NO_____
DATE AND CAUSE OF DEATH:

RELATIONSHIP WITH MOTHER—PAST/PRESENT:

NAME OF BROTHERS/SISTERS, AGES, RELATIONSHIP WITH SIBLINGS:

***EDUCATION**

LAST GRADE ATTENDED _____ GRADES_____

NAME OF LAST SCHOOL _____

PROBLEMS IN SCHOOL (expulsions, suspensions, withdrawal)

COLLEGE / TRADE SCHOOL: YES____ NO____

DEGREE: _____

SCHOOL NAME: _____

***MILITARY SERVICE**

BRANCH _____ YEARS _____

DISCHARGE TYPE / RANK: _____

HIGHEST RANK: _____

DISCIPLINARY ACTIONS:

***EMPLOYMENT**

WHERE _____

LENGTH OF TIME _____HOURS/SHIFT _____

JOB _____

*HOURLY PAY OR SALARY _____

SUPPLEMENTAL INCOME (Child Support / Social Security Disability / Veterans Benefits)

STAFF COMMENTS

* Denotes area required in governing rules.

***SOCIAL AND PEER GROUP**:
(type and amt of friends, hobbies)

STAFF COMMENTS

***HISTORY OF MEDICAL PROBLEMS:**

***HISTORY OF MENTAL HEATLH PROBLEMS:**

*CURRENT/RECENT THOUGHTS OF SUICIDE/HOMICIDE _____

PLAN? _____YES _____NO (if yes, what is the plan?)

CLIENT VICTIMIZATION: PHYSICAL_____ SEXUAL _____

VERBAL / EMOTIONAL _____

INFORMATION REGARDING ABUSE:

***HISTORY OF SUBSTANCE ABUSE:**

*SUBSTANCE(S) OF
PREFERENCE_____

*HISTORY OF SUBSTANCE ABUSE INTERVENTION (Education, Outpatient, Detox, IOP, Residential, Halfway House):
(date, where, type of intervention, reason for intervention)

***HISTORY OF SUBSTANCE ABUSE/ADDICTION IN FAMILY AND ATTITUDE TOWARD SUCH USE:** (relationship to client and substance used)

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*Type of Drug	*Ever used	*Use last 48 hrs	*DATE of Last Use	*How used	*Age First Use	*Frequency of Use	*Adverse Reactions	*Over-doses W/D	*Drug of Choice
Alcohol	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Marijuana	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Cocaine	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Heroin	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Methamphetamine	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Amphetamines: Dexedrine, Provigil, Adderall, Ritalin, Cylert, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Barbituates: Seconal, Phenobarbital, Amytal, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Benzodiazepines: Xanax, Valium, Ativan, Klonopin, Halcion, Librium, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Narcotics: Morphine, Vicodin, Loratab, Oxycontin, Darvon, Percocet, Methadone, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Hallucinogens/Psychedelics: LSD, PCP, "magic mushrooms," ectasy, ketamine, DMT, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Inhalants: Paint sprays, glue, gasoline, aerosols, nitrous oxide, "whippits," etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Psychotropic Medication: Prozac, Zoloft, Paxil, Risperdal, Zyprexa, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Nicotine: Cigarettes, cigars, snuff, chew, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Caffeine: Coffee, tea, soft drinks, No Doz, Vivarin, etc.	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Over the Counter Medication	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No
Other	☐Yes ☐No	☐Yes ☐No							☐Yes ☐No

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***PHYSICAL SYMPTOMS (Adverse Reactions)**

SUBSTANCE(S)

HANGOVERS_____

PASSOUTS_____

BLACKOUTS_____

TOLERANCE_____

LOSS OF CONTROL_____

RELIEF USE_____

OVERDOSE_____

ADVERSE DRUG REACTION_____

WITHDRAWAL SYMPTOMS (SPECIFY)_____

_____

WHO HAS EXPRESSED CONCERN ABOUT *YOUR* USE:

CLIENT IDENTIFIED SYMPTOMS OF CONCERN:

ADDITIONAL SERVICES INDICATED: (Please circle all that apply)

Workforce Development	AFDC	Medicaid/Medicare
Food Stamps	Medical/Clinic	Housing

Other_____

STAFF COMMENTS

_____
Professional Staff Member

_____
Date

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