The Wives, Inc.

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Adult Self Report Form

This form is completely confidential

Today's date: _____

Your name: _____Date of birth: _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

Please briefly describe your presenting concern(s):

_____
_____
_____
_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place: List the onset and frequency of each checked behavior/symptom (i.e., 2 months ago, 3-4x wk)

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Panic attacks
___Fainting
___Blackouts
___Nightmares
___Fidgeting
___Hyperactivity
___Flashbacks
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood changes
___ Headaches
___Nausea
___ Sweating
___ Chills/Hot flashes
___ Short Attention span
___ Difficulty with Finances
___Repetitive Behaviors
___Difficulty trusting others
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Sleeping too much
___ Feeling Manic
___Abdominal Distress
___Shortness of Breath
___Severe Weight Gain/Loss
___Pain in joints
___Difficulty with Relationships
___Muscle tension
___Other_____

Briefly discuss how the above symptoms impair your ability to function effectively:

_____
_____

1. Are you having thoughts of hurting yourself or someone else? YES NO

PAST TREATMENT

2. Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? Y N

If yes, when, where, and with whom?_____

3. Did you find past treatment helpful? YES NO

4. Previous psychiatric hospitalizations (Approximate dates and reasons):
_____

5. Are you currently under the care of a psychiatrist, therapist, or your primary care provider for a psychiatric problems? YES NO

6. Are you currently taking any psychiatric medications? YES NO

If yes, please list name(s) and dosage(s):_____

_____

7. Have you ever taken any psychiatric medications in the past that you are no longer taking? YES NO

If yes, please list name(s) and dosage(s):_____

MEDICAL HISTORY:

8. Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

9. When was the last time you were seen by a doctor?_____

10. Would you like information from today's visit communicated to your primary care provider or any other medical doctor? YES NO

11.Do you have a history of head injury, seizures or loss of consciousness? YES NO
If yes, please explain: _____

12. (Women only) Are you pregnant? YES NO

13. Do you have pain management issues? YES NO

14. Previous medical hospitalizations (Approximate dates and reasons):_____
_____

15. Do you smoke or use tobacco? YES NO If YES, how much per day?_____
16. Do you consume caffeine? YES NO If YES, how much per day? _____

Substance Abuse

17. Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex, etc)? Y N

18. Do you currently attend support groups? YES NO If yes, please list: _____

19. Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

20. Circle the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants.

21. Have you experienced withdrawal symptoms? YES NO If yes, circle all which apply: withdrawal, headaches, nausea, vomiting, tremors, seeing things, hearing things, other

22. Have you ever had a DUI? YES NO

23. Have any of your friends or family members voiced concern about your substance use? YES NO

24. Have you ever been in trouble or in risky situations because of your substance use? YES NO

LEGAL ISSUES

25. Do you have any current legal issues? YES NO If yes, please describe: _____

26. Are you currently on probation/parole? YES NO

27. Do you have a DFACS worker? YES NO

FAMILY:

FAMILY/RELATIONSHIPS

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother						
Father						
Spouse						
Children						
Siblings						
Other						

28. Please list anyone not listed above who lives in your home, his/her age, and relationship: _____

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

29.How would you describe your relationship with your mother?_____

_____

30. How would you describe your relationship with your father?_____
_____

31. Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

32. Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____
_____

33. How would you describe your relationships with your siblings?
_____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Marital Status (more than one answer may apply)

___ Single __Divorce in process __ Unmarried, living together
Length of time: __ Length of time: _____
___ Legally married ___ Separated ___ Divorced
Length of time: ____ Length of time: _____ Length of time: _____
___ Widowed ___ Annulment
Length of time: _____ Length of time: _____ Total number of marriages: __
Assessment of current relationship (if applicable): _____ Good ___ Fair ____ Poor

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

34. Please briefly describe your coping mechanisms and self-care:_____

35. Is spirituality important in your life and if so please explain: _____

35. How would you describe your diet and exercise patterns? Poor 1 2 3 4 5 6 7 8 9 10 (Excellent)

EDUCATION & CAREER

36. High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

37. Circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired

38. What is your current employment (if applicable)
_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

39. Did you experience difficulties in school? YES NO. If yes, please list: _____

OTHER AREAS OF CONCERN

40. Do you have any history of abuse, neglect and/or trauma? Yes No.

41. What are your hobbies/interests?_____

42. Do you have any sexual orientation/gender issues or concerns? YES NO

43. Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ Transgender__ In Question__

44.Are you having difficulties with spiritual or religious matters? YES NO

45. Do you have difficulties or concerns about how you get along with other people? YES NO

46. Any additional information you would like to include:

_____

_____

47. What are your goals for therapy? What would you like to see changed?

_____

_____

Signature of Client (or person completing form) _____ Date_____

Signature of Therapist _____Date_____