Behavior Assessment – Family Member

Presenting Problem

How did you hear about our program?

Describe what is happening in their life that helped he/she make the decision to enter treatment at this time:

How does he/she see their mental health issues directly affecting their life? Example: not doing things with family, etc?

Has their issues impacted anyone else besides himself/herself?

Intrapersonal Issues

Physical Health

How would you describe their health on a scale of 1 to 10? **(10 being the Best they ever felt.)**

Scale: 10

Current medications prescribed for medical purposes and over the counter drug used, including vitamins and herbal medications:

Weight: ☐ Underweight, or ☐ Overweight. By # of lbs.

Patient's nutritional status: # of meals a day _____. Do they eat a balanced diet? ☐ Yes ☐ No

Does he/she have difficulty with shopping, cooking or hygiene? ☐ Yes ☐ No

Sleep Patterns: Does he/she have a regular bedtime and wake up time? ☐ Yes ☐ No. Sleep ☐ hours per night

Do they feel rested when they wake up? Yes No Do they take naps regularly during the day? Yes No
Do they have any other medical conditions? Yes No If yes what?
Do they have a primary care physician? Yes No If yes – Name
Do they have any limitations that impact daily activities? Yes No If yes what?

Pain Issues: What is their current level of pain (0-to-10, with 0=None, 10=Worst)?
How long have they been having this pain?
Describe the probable source of the pain they are having.

Mental Health or other Emotional Issues

Has there ever had a significant period in which they experienced the following?

- Anxiousness/nervousness
- Grief and loss issues
- Inability to comprehend
- Sleep disturbances
- Loss of appetite
- Serious depression
- Isolation
- Loss of motivation
- Numb (no emotional life)
- Lonely
- Eating disorder(s); if checked; Anorexia, Bulimia
- Anger
- Hostility/violence
- Self-esteem problems
- Shyness
- Shame
- Stress
- Boundaries (too passive – too aggressive)
- Phobias/paranoia/delusions
- Clouded or confused thinking
- Trouble with writing
- Hallucinations. If checked, also note: Audio Visual
- Trouble with reading
- Other(s):

What is your rating of their mental health? Poor Average Good Excellent
Do they like themselves? Yes No Explain:

Is there anything they did in their past that still bothers you today? No Yes, If yes; Describe:

Suicide Ideation/Attempts

Do they have a family history of suicide? Yes No If yes; explain:

Have they ever (past or present) thought about committing suicide? Yes No If yes date of last thought:
Do they have a current plan to harm themselves? Yes No If yes evaluate level of risk.
Current level of RISK: 10

If risk is above a 5 then a No-Harm Contact must be signed. If risk is above an 8 and client is unable to contract for safety call a CDMHP.

Violence/Abuse History

Do they have homicidal thoughts? Yes No. If yes explain:
Do they have a history of combative or assaultive behavior? Yes No. IF yes date of last thought:
Do they have a current plan to harm themselves? Yes No If yes evaluate level of risk.
Have they ever been *physically* abused? Yes No If yes explain:

Have they received counseling for this issue? Yes No If yes, by whom:
Have they ever been *sexually* abused? Yes No If yes explain:

Have they received counseling for this issue? Yes No If yes, by whom:
Have they ever been *emotionally* abused? Yes No If yes explain:
Have they received counseling for this issue? Yes No If yes, by whom:
Have they ever been accused of sexually abusing anyone else? Yes No if yes, victim(s) (gender, age, family or not, etc… do not include names) and their age(s) at time(s) of committing abuse(s):

Was their abuse reported to the authorities? Yes No If yes what was the Outcome?
Are they required to register as a sex offender? Yes No. Indicate Level: I II III. (if II or III, do an Offender Contract)
If "Yes," is their registration current? Yes No List State/County:
(Note to counselor: Obtain releases to County Sheriff where involved, and any other relevant Legal Information)

INTERPERSONAL

Does he/she have children? Yes No Are any of his/her children not in their care? Yes No
If yes explain (including any loss of parental rights):
What community supports does he/she have?
Does he/she have supportive family members? Yes No Supportive friends? Yes No
Is he/she currently in a relationship? Yes No Is his/her Spouse/SO supportive? Yes No
Current living situations?
Who else is supportive of his/her partner's efforts to get well?
What do they do for fun – leisure activities?
During the past 12 months has he/she had any significant relationship problems with his/her spouse/family members due to their issues?
Yes No If yes what?
On a scale from 1 to 10 with 10 being "I will do whatever it takes to support them to get better emotionally"? (**10 being the Best)**
Scale: 10

Educational - Vocational

Does he/she have any military history? Yes No IF yes explain:
Has he/she worked in the last 6 months? Yes No Primary occupation:

If yes explain (include job titles and last full time employment):

Have they ever been wrote up or reprimanded at work due to their behavior? Yes No If yes explain:

Have they ever committed illegal acts because of their mental health issues? Yes No If yes explain:

LEGAL

Have they ever been in trouble with the law? Yes No If Yes, Why?
Does she/he have any upcoming court dates? Yes No Are they currently on probation? Yes No
Have they been court ordered to do participate in services? Yes No If yes explain:

FINANCIAL

Does he/she have funds for basic needs? Yes No Has he/she ever had any items repossessed? Yes No
Is he/she struggling or feeling stress about their finances? Yes No
Does he/she have credit cards? Yes No Are they maxed out? Yes No
Does he/she have a checking account? Yes No Does he/she balance it: Daily Weekly Monthly Never

Spiritual

Does he/she currently identify with any organized religion? Yes No. Or other spiritual beliefs/practices? Yes No
Please explain:
Does he/she believe in a higher power? Yes No
Explain:
Does he/she believe that what goes around comes around? Yes No
Explain: