ECAR-Research Evaluation and Counseling Services

Behavior Assessment – Individual

Presenting Problem

How did you hear about our services? ____

Who referred you?___________**Or**, describe what is happening in your life that lead to you decision to seek treatment at this time? :
____
____
____
____

How do you see your issues/concerns directly affecting your life? Example: not doing things with family, using household funds to for other things, etc?
____
____
____
____

Have your issues/concerns impacted anyone else besides yourself?
____
____

Intrapersonal Issues

Physical Health

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

Scale:

Counselor's observation of patient's physical health: Poor ☐ Average ☐ Good ☐ Excellent ☐

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

Weight: Client's report: ☐ underweight, or ☐ overweight. By # of lbs. ________________________________

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

Do you have difficulty with shopping, cooking or hygiene? ☐ Yes ☐ No

Sleep Patterns: Do you have a regular bedtime and wake up time? ☐ Yes ☐ No. Sleep ____________ hours per night

Do you have any other medical conditions? ☐Yes ☐No If yes what____

Do you have a primary care physician? ☐Yes ☐No If yes – Name ______________________________ Date last seen___________

Do you have any limitations that impact daily activities? ☐Yes ☐No If yes what? _______________________________________

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

Mental Health or other Emotional Issues

Have you ever had a significant period in which you 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

Counselor's rating of the patient's mental health? ☐ Poor ☐ Average ☐ Good ☐ Excellent

Do you like yourself? ☐ Yes ☐ No Explain: ____

____

Is there anything you did in your past that still bothers you today? ☐ No ☐Yes, if yes: Describe:

____

____

Suicide Ideation/Attempts

Do you have a family history of suicide? ☐ Yes ☐ No If yes explain: ____

Have you ever (past or present) thought about committing suicide? ☐ Yes ☐ No If yes date of last thought: ______________

Do you have a current plan to harm yourself? ☐ Yes ☐ No If yes evaluate level of risk.

Current Level of RISK: ***If risk is above a 5 then a No-Harm Contract must be signed. If risk is above an 8 and client is unable to contract for safety call a CDMHP.***

Violence/Abuse History

Do you have homicidal thoughts? ☐ Yes ☐ No If yes explain: ____

Do you have a history of combative or assaultive behavior? ☐ Yes ☐ No If yes explain: ___________________________

Have you ever been *physically* abused? ☐ Yes ☐ No If yes explain: _______________________________________

____

Have you received counseling for this issue? ☐ Yes ☐ No If yes, by whom: __________________________________

Have you ever been *sexually* abused? ☐ Yes ☐ No If yes explain: ____

____

Have you received counseling for this issue? ☐ Yes ☐ No If yes, by whom: __________________________________

Have you ever been *emotionally* abused? ☐ Yes ☐ No If yes explain: ______________________________________

____

Have you received counseling for this issue? ☐ Yes ☐ No If yes, by whom: __________________________________

Have you 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 your age(s) at time(s) of committing abuse(s): ____

____

Was your abuse reported to the authorities? ☐ Yes ☐ No If yes, what was the Outcome? _________________________

Are you 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 your registration current? ☐Yes ☐No List State/County _______________________________________

(Note to counselor: Obtain releases to County Sheriff where involved, and any other relevant Legal information)

INTERPERSONAL

Do you have children? ☐ Yes ☐ No Are any of your children not in your care? ☐ Yes ☐ No
If yes explain (including any loss of parental rights): ______________________________
What community supports do you have? ______________________________
Do you have supportive family members? ☐ Yes ☐ No Supportive friends? ☐ Yes ☐ No
Are you currently in a relationship? ☐ Yes ☐ No is your Spouse/SO supportive? ☐ Yes ☐ No
Current living situations? ______________________________
Who else is supportive of your needs? ______________________________
What do you do for fun – leisure activities? ______________________________
During the past 12 months have you had any significant relationship problems with your spouse/partners due to issues?
☐ Yes ☐ No If yes what? ______________________________

Educational - Vocational

Do you have any military history? ☐ Yes ☐ No IF yes explain: ______________________________
Have you worked in the last 6 months? ☐ Yes ☐ No Primary occupation: ______________________________

If yes explain (include job titles and last full time employment): ______________________________
____
Have you ever been wrote up or reprimanded at work due to your issues? ☐ Yes ☐ No If yes explain: ____________
____
Have you ever stolen from work to support your needs? ☐ Yes ☐ No If yes explain: ____________
____

LEGAL

Have you ever been in trouble with the law? ☐ Yes ☐ No If Yes, was it due to your issues? ☐ Yes ☐ No
Do you have any upcoming court dates? ☐ Yes ☐ No Are you currently on probation? ☐ Yes ☐ No
Have you been court ordered to do participate in services? ☐ Yes ☐ No If yes explain: ______________________________

FINANCIAL

Do you have funds for basic needs? ☐ Yes ☐ No Have you ever had any items repossessed? ☐ Yes ☐ No
Are you struggling or feeling stress about your finances? ☐ Yes ☐ No
Do you have credit cards? ☐ Yes ☐ No Are they maxed out? ☐ Yes ☐ No
Do you have a checking account? ☐ Yes ☐ No Do you balance it: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Spiritual

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