Adult Self-Report

Client Name: ____ Date: ________________

Referral Source: ____

Presenting Concerns

Describe the concerns that bring you to West River Mental Health: ______________________________

____

How long have you been experiencing these concerns? ____________________________________

What have you done to address these concerns? ____

Any other concerns? ☐Family ☐Marital ☐Work ☐Legal ☐Money ☐School ☐Social ☐Housing

☐Other: ____

What are your goals for services (Hopes and Dreams)? ____________________________________

____

Substance Use

Alcohol: Never Rarely Moderate Daily

Tobacco/Nicotine: ☐Never ☐Previous, but quit: __________ Type/Frequency: ______________

Illicit Drugs: ☐Never ☐Type/Frequency: ____

Prescription/OTC Drugs: ☐Never ☐Type/Frequency: ______________________________________

UNCOPE

☐Yes ☐No Have you spent more time drinking or using than you intended to?

☐Yes ☐No Have you ever neglected some of your usual responsibilities because of alcohol or drugs?

☐Yes ☐No Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

☐Yes ☐No Has your family, friend, or anyone else told you they objected to your alcohol or drug use?

☐Yes ☐No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

☐Yes ☐No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger or boredom?

PES

Pre-Employment Activities

Education/Training – I understand the educational and training opportunities available to me and I am able to access them.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like me

Comments:____

____

Personal Career Planning – I understand how to access services to assist me in career-related issues to gain employment.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like me

Comments:____

____

Employment Opportunities – I am able to identify and find employment opportunities consistent with my strengths, abilities and preferences.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like me

Comments:____

____

Support Employment and Work Practices

Supported Employment – I understand my role at work and use job coaching and support at my work site.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like me

Comments:____

____

Work History – I have worked consistently in the past and I am able to maintain employment.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like me

Comments:____

____

Gainful Employment – I understand how employment income will affect benefits.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like me

Comments:____

____

I have been successful in the interview process and I am able to get and maintain a job.

☐This is just like me ☐This is mostly like me ☐Somewhat like me ☐Less like me ☐Not at all like

Comments:____

____

Current Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Not in Labor Force

Place of employment and hours worked per week: ____

Psychosocial History

Family and Developmental History (past and current relational and family situation)

☐Yes ☐No Concerns ☐Unknown ☐Add Health Issues to Needs List

Comments:____

____

Current Living Arrangement: ____

Describe your current and past legal involvement:

____

____

Social Supports

Who/what do you consider your support system? ____

Do you have any community supports? ____

What meaningful activities are you involved in (or would like to be)? ______________________________

Have you experienced abuse or neglect either as a victim or perpetrator and/or has had a previous traumatic incident? ☐Yes ☐No concerns

Comments:____

____

Are there cultural/ethnic/religious issues that are of concern or need to be addressed? Describe cultural/ethnic/religious values or beliefs:

____

____

Please discuss any issues with school, schools attended, and current and past academic performance:____

____

Mental health treatment history. List previous diagnosis, family history, and previous treatment:

____

____

Medication:

Name: ________________ Dosage/Frequency: ____________ Purpose: ________ Prescriber: __________

Name: ________________ Dosage/Frequency: ____________ Purpose: ________ Prescriber: __________

Name: ________________ Dosage/Frequency: ____________ Purpose: ________ Prescriber: __________

Are you satisfied with how these medications are working for you?

____

Current Primary Care Physician: ____

Have you had any of the below factors that may have put you at risk for a communicable disease such as HIV/AIDs, STDs, Hepatitis B or C, or TB?

	If yes:
Unprotected sexual relations with more than one partner during the last 24 months?	☐
Sexual relations with anyone who is infected with HIV/AIDs, Hepatitis, or an STD?	☐
Sexual relations with anyone who injects drugs?	☐
Injected drugs or shared needles?	☐
Received money, drugs or other favors for sexual relations?	☐

Anxiety

Have your feelings caused you distress or interfered with your ability to get along socially with friends or family?
☐Yes ☐No

How often have you felt nervous, anxious, or on edge?
☐Almost always ☐Almost never ☐Most of the time ☐Some of the time

How often were you not able to stop worrying or controlling your worry?
☐Almost always ☐Almost never ☐Most of the time ☐Some of the time

How often is stress a problem for you handling such things as: health, finances, family, social relations, or work?
☐Almost always ☐Almost never ☐Most of the time ☐Some of the time

PHQ9

Over the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Feeling down, depressed or hopeless:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Trouble falling or staying asleep or sleeping too much:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Feeling tired or having little energy:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Poor appetite or overeating:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Feeling bad about yourself – or that you are a failure or have let yourself or your family down:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Trouble concentrating on things such as reading the newspaper or watching television:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you were moving around more than usual:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

Thoughts that you would be better off dead or hurting yourself:
☐Not at all ☐Several days ☐More than half ☐Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐Not difficult at all ☐Somewhat difficult ☐ Very difficult ☐Extremely difficult

Risk Assessment

Have you had recent thoughts about: ☐Not wanting to live ☐Hurting yourself ☐Hurting someone else
☐Not applicable

Comments: ______________________________

Have you ever: ☐Made a suicide attempt ☐Injured yourself on purpose ☐Overdosed on purpose or accident
☐Not applicable

Comments: ______________________________

Please list any other safety concerns: ______________________________

Have you had any significant losses in the past 2 years? ______________________________

Do you have difficulty (past or present) with anger management? ☐Yes ☐No

Explain:______________________________

____

Advance Directive

Do you have an Advance Directive? ☐Yes ☐No

Do you desire an Advance Directive plan? ☐Yes ☐No

Would you like more information about Advance Directive planning? ☐Yes ☐No

Discuss treatment focus and your preferences for services:

____

____

____

Strengths:____

____

____