Client Background Information

Name:	**Date:**
Address 1:	DOB: Age:
Address 2:	Sex: [ ] F [ ] M Marital Status:
City: St: Zip:	Employed: [ ] FT [ ] PT [ ] Stud [ ] Other
Phone:	
Email:	Spouse/Partner Name:

1. LIVING ARRANGEMENTS: (check one)

☐ Homeless ☐ Private residence alone ☐ Living with relatives ☐ Private residence with non-relative

Are You Having Any Difficulties Or Concerns About The Place Where You Live? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty **2** More than a little **3** Moderate difficulty **4** Quite a bit **5** Serious difficulty

2. FAMILY AND SOCIAL LIFE (Please give the requested information below.)

Names of Children	**Date of Birth**	**Lives With?**		**Stepchild?**	
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No

Others who live with you? Please list below:	Age:	Relationship:

Are You Having Any Difficulties Or Concerns About How You Get Along With Other People? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty **2** More than a little **3** Moderate difficulty **4** Quite a bit **5** Serious difficulty

Are You Having Any Difficulties With Spiritual Or Religious Matters? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty **2** More than a little **3** Moderate difficulty **4** Quite a bit **5** Serious difficulty

Do You Have Any Sexual Orientation Issues Or Concerns? ☐ Yes ☐ No

If yes, on a scale of one to five, how much concern you are having: (please circle one number)

1 Minor concern **2** More than a little **3** Moderate concern **4** Quite a bit **5** Serious concern

Are You Having Any Difficulties Or Concerns About How You Spend Your Time? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty **2** More than a little **3** Moderate difficulty **4** Quite a bit **5** Serious difficulty

Are you having any difficulties relating to alcohol or other drug use (self or others)? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty **2** More than a little **3** Moderate difficulty **4** Quite a bit **5** Serious difficulty

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Are You Having Any Difficulties Relating To Gambling (yourself Or Others)? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty	**2** More than a little	**3** Moderate difficulty	**4** Quite a bit	**5** Serious difficulty

3. BASIC NEEDS

Are You Concerned About Any Basic Needs Such As Food And Clothing? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty	**2** More than a little	**3** Moderate difficulty	**4** Quite a bit	**5** Serious difficulty

Are You Having Any Difficulties Getting Where You Need To Go (transportation)? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty	**2** More than a little	**3** Moderate difficulty	**4** Quite a bit	**5** Serious difficulty

4. Employment:

	I work full time over 30 hours
	I work part time under 30 hours
	I am unemployed, looking for work
	I am unemployed, not looking for work
	Retired
	Other

Military Experience

Are you a veteran?	Yes	No
Do you have combat experience?	Yes	No
Explain:		
Year drafted / enlisted:		
Year discharged:		
Type of discharge:		

Are You Having Any Difficulties Or Concerns About Your Job? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty	**2** More than a little	**3** Moderate difficulty	**4** Quite a bit	**5** Serious difficulty

5. EDUCATION (Please check one:)

☐ In school ☐ In training program ☐ Less than high school ☐ Completed high school ☐ Some college ☐ College Graduate

Are You Having Any Difficulties Or Concerns In Regards To Your Education? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty	**2** More than a little	**3** Moderate difficulty	**4** Quite a bit	**5** Serious difficulty

6. LEGAL PROBLEMS

Are You Currently Involved In Any Legal Action (civil Or Criminal)? ☐ Yes ☐ No

If yes, please describe: _____

Are You Currently On Probation Or Parole? ☐ Yes ☐ No

Are You Having Any Difficulties Regarding Legal Concerns? ☐ Yes ☐ No

If yes, on a scale of one to five, how much difficulty you are having: (please circle one number)

1 Minor difficulty	**2** More than a little	**3** Moderate difficulty	**4** Quite a bit	**5** Serious difficulty

7. HEALTH AND SAFETY

Primary Care Physician:		Ph:
When did you last see your physician?		Reason?
Are you currently pregnant?	[ ] Yes	[ ] No
Do you have any disability restrictions?	[ ] Yes	[ ] No

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Disability:	Restrictions:

Are You Currently Taking Any Prescribed Medication? (If Yes, Please List Below:)				
Name of medication:	**Dose:**	**How Often:**	**Reason?**	**Prescribed by?**

Have you ever used:	**Yes**	**No**	**Form?**	**How long used?**	**How often used?**	**Quantity?**
Alcohol?						
Tobacco?						
Non-Rx drugs						
Herbal remedies?						
Injected drugs?						
Caffeine						

NUTRITIONAL INFORMATION

How many meals do you eat a day?	How many snacks in a normal day?
Give examples of what you would eat in a normal day [include snacks]:	
Do you consider yourself: [ ] Underweight [ ] Overweight How many pounds?	
Are you on any special diet? [ ] No [ ] Yes	Explain:
How has your weight changed in the past six [6] months?	
Do you have problems with: [ ] chewing [ ] swallowing [ ] choking [ ] nausea [ ] binge eating [ ] purposeful vomiting [ ] none of these	

If there is anything else you would like say about your medical history or health and safety issues, please write it here and on the back.