

Person giving information: \_\_\_\_\_ Relationship: \_\_\_\_\_

**A. Presenting Problem/ Current Crisis Symptoms**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Risk Assessment (Check All that apply)**

**SUICIDE**  
 Reported this is not a problem  
 Ideation  
 Plans  
 Means  
 Prior attempts  
dates: \_\_\_\_\_

**HOMICIDE**  
 Reported this is not a problem  
 Ideation  
 Plans  
 Means  
 Prior attempts  
dates: \_\_\_\_\_

Crisis Plan or comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Treatment History**

Mental Health

Support Group \_\_\_\_\_  
 Outpatient \_\_\_\_\_  
 Partial \_\_\_\_\_  
 Inpatient \_\_\_\_\_  
 Case Management \_\_\_\_\_  
 Medication only services \_\_\_\_\_

Substance Abuse

Support Group \_\_\_\_\_  
 NA/AA \_\_\_\_\_  
 Outpatient \_\_\_\_\_  
 Detoxification \_\_\_\_\_  
 Inpatient \_\_\_\_\_  
 Half-way house \_\_\_\_\_

**D. Substance Use/Abuse:**

Type	Frequency	Amount	Consequences/Impairment	Last Use
<input type="checkbox"/> Alcohol	_____	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____	_____
<input type="checkbox"/> Cocaine	_____	_____	_____	_____
<input type="checkbox"/> Tobacco	_____	_____	_____	_____
<input type="checkbox"/> Other Addictions	_____	_____	_____	_____

**E. Medical Information**

Current Medical conditions and medications (bring for first appointment)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F. How do these problems affect other areas of your life? (Include legal involvement)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. What is your goal for treatment?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**H. For children – Legal guardian:** \_\_\_\_\_ (bring documentation)

Person taking this information: \_\_\_\_\_ Date: \_\_\_\_\_

Reg. ID# \_\_\_\_\_ Client Name: \_\_\_\_\_