Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

Client Information
Client Name (First)_____ (MI)___ (Last)_____
Marital Status: _____
Address_____ City _____
State _____ Zip _____
Phone No. (Home) (____) _____ (Work) (____) _____
Cell (___) _____
Social Security Number _____ Sex: F □ M □ Age _____
Date of Birth ___/___/___

Parent/Guardian or Partner (IF CLIENT IS A MINOR OR CAREGIVER FOR ADULT)

Name (First) _____ (MI) ___ (Last) _____
Marital Status: _____
Address _____ City _____ State _____
Zip _____
Phone No. (Home) (____) _____ (Work) (____) _____
Cell (____) _____
Relationship: Spouse □ Parent/Legal Guardian/Caregiver □ Other □: _____

Physical/Medical Provider

Name _____
Agency/Organization _____
Address _____ City _____ State _____
Zip _____
Office Phone (____)_____ Fax (____) _____
□ Signed Release? _____

Psychiatrist/Counselor

Name _____
Agency/Organization _____
Address _____ City _____ State _____
Zip _____
Office Phone (____) _____ Fax (____) _____
□ Signed Release? _____

Notes: _____

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

School Information (IF CLIENT IS CHILD)

Teacher/Staff Name _____
Grade _____School _____
Address _____ City _____
State ____ Zip _____ Contact name: _____
Office Phone (____) _____ Fax (____) _____
□ Signed Release? _____
Please use space below for additional children's school information:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Employer
Name _____
Agency/Organization _____
Address _____ City _____
State _____ Zip _____
Office Phone (____) _____ Fax (____) _____
□ Signed Release? _____

Referral Service

Name _____
Agency/Organization _____
Address _____ City _____ State _____ Zip _____
Office Phone (____) _____ Fax (____) _____ □ Signed Release?

Presenting Problem
Please identify your primary concerns or symptoms:
_____
_____
_____
_____
_____

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

Please rate the current intensity of symptoms for each of the following:

	None	Mild	Mod.	Severe		None	Mild	Mod.	Severe
Learning Problems	☐	☐	☐	☐	Elevated Mood	☐	☐	☐	☐
Motor Skill Problem	☐	☐	☐	☐	Decreased Sleep	☐	☐	☐	☐
Communication Deficit		☐	☐	☐	☐Pressured Speech	☐	☐	☐	☐
Speech Impairment	☐	☐	☐	☐	Racing Thoughts	☐	☐	☐	☐
Repeats Words	☐	☐	☐	☐	Distractibility	☐	☐	☐	☐
Repetitive Behavior	☐	☐	☐	☐	Excessive Behavior	☐	☐	☐	☐
Poor Peer Relation	☐	☐	☐	☐	Panic Attacks	☐	☐	☐	☐
Inattention	☐	☐	☐	☐	Excessive Anxiety	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Avoidance	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐	Phobia	☐	☐	☐	☐
Aggressive Behavior	☐	☐	☐	☐	Obsessive Thoughts	☐	☐	☐	☐
Animal Cruelty	☐	☐	☐	☐	Exposure to Trauma	☐	☐	☐	☐
Property Destruction	☐	☐	☐	☐	Compulsive Behavior	☐	☐	☐	☐
Chronic Lying	☐	☐	☐	☐	Intrusive Memories	☐	☐	☐	☐
Stealing	☐	☐	☐	☐	Sleep Disturbances	☐	☐	☐	☐
Conduct Problems	☐	☐	☐	☐	Nightmares	☐	☐	☐	☐
Easily Loses Temper	☐	☐	☐	☐	Flashbacks	☐	☐	☐	☐
Oppositional Beh.	☐	☐	☐	☐	Hypervigilance	☐	☐	☐	☐
Eating Non-Food	☐	☐	☐	☐	Loss of time	☐	☐	☐	☐
Tics/Twitches	☐	☐	☐	☐	Detachment	☐	☐	☐	☐
Anger Outbursts	☐	☐	☐	☐	Immaturity	☐	☐	☐	☐
Inapp. Sexual Beh.	☐	☐	☐	☐	Not Trustworthy	☐	☐	☐	☐
Clinginess	☐	☐	☐	☐	Self Injurious Threats	☐	☐	☐	☐
Lack of attachment	☐	☐	☐	☐	Distrustful	☐	☐	☐	☐
Memory Impairment	☐	☐	☐	☐	Disorientation	☐	☐	☐	☐
Cognitive Impairment	☐	☐	☐	☐	Drug Abuse	☐	☐	☐	☐
Alcohol abuse	☐	☐	☐	☐	Delusions	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Paranoia	☐	☐	☐	☐
Poor Hygiene	☐	☐	☐	☐	Depressed Mood	☐	☐	☐	☐
Diminished Interest	☐	☐	☐	☐	Sig. Weight loss/gain	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	Fatigue	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	Elevated Mood	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Feeling Worthless	☐	☐	☐	☐
Inappropriate Guilt	☐	☐	☐	☐	Poor Concentration	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐	Irritability	☐	☐	☐	☐
Low Self Esteem	☐	☐	☐	☐	Unresolved Guilt	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐	Chronic Pain	☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐	Impaired Sensory Fx	☐	☐	☐	☐
Memory Problems	☐	☐	☐	☐	Dissociation	☐	☐	☐	☐
Sexual Dysfunction	☐	☐	☐	☐	Excessive Dieting	☐	☐	☐	☐
Gambling	☐	☐	☐	☐	Self Mutilation	☐	☐	☐	☐
Witness to DV	☐	☐	☐	☐	Phys./Emotion Abuse	☐	☐	☐	☐
Sexual Abuse victim	☐	☐	☐	☐	Cardio Disease	☐	☐	☐	☐
Respiratory Diseases	☐	☐	☐	☐	Neurological Diseases	☐	☐	☐	☐
Endocrine Diseases	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐

Narrative (For Office Use Only)

_____
_____
_____
_____
_____
_____
_____

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

_____
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_____

Family History

Parents:

Mother's Name _____ Biological □ Adoptive □
Father's Name_____ Biological □ Adoptive □
Stepmother's Name _____
Stepfather's Name _____

How often do/did parents argue or fight?
Rarely □ Occasionally □ Frequently □ N/A □
How do/did parents work out their differences with each other?
Talk□ Shout □ Silence □ Left house □ Other □

Siblings □ N/A-client has no siblings
Sibling Name
_____
Sex: F□ M□ Status of Sibling: Living □ Deceased □ *If Deceased, what year?*_____
Current Relationship with Sibling: Positive □ Negative □ Neutral □ Abusive □ Absent □

Sibling Name_____
Sex: F□ M□ Status of Sibling: Living □ Deceased □ *If Deceased, what year?* _____
Current Relationship with Sibling: Positive □ Negative □ Neutral □ Abusive □ Absent □

Sibling Name _____
Sex: F□ M□ Status of Sibling: Living □ Deceased □ *If Deceased, what year?* _____
Current Relationship with Sibling: Positive □ Negative □ Neutral □ Abusive □ Absent □

Sibling Name _____
Sex: F□ M□ Status of Sibling: Living □ Deceased □ *If Deceased, what year?* _____
Current Relationship with Sibling: Positive □ Negative □ Neutral □ Abusive □ Absent □

Sibling Name _____
Sex: F□ M□ Status of Sibling: Living □ Deceased □ *If Deceased, what year?* _____
Current Relationship with Sibling: Positive □ Negative □ Neutral □ Abusive □ Absent □

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

Marital Status
Current Marital Status: Single □ Engaged □ Married □ Divorced □ Widowed □
Separated □ Involved □ Other □

Partner □N/A- client is not involved
Current Partners Name _____ Age: _____
Former Partner's Name, if applicable
_____ Age: _____

Children □ N/A- client has no children
Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Child's Name
_____
Sex: □ F □ M Date of Birth: ____/____/____

Pregnancy/Delivery
Was the pregnancy normal? □ No □ Yes
Was the pregnancy full term? □ No □ Yes
Birth Weight _____lbs. _____ oz.

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

Pregnancy Complications (check all that apply)

□ None	□ Drug Use	□Kidney Infection
□Alcohol Use	□ Emotional Stress	□ Psychiatric Impairment
□ Bleeding	□ Gestational Diabetes	□ Tobacco Use
□Domestic Violence	□ High Blood Pressure	□ Other: _____

Birth Complications (check all that apply)

□None	□ Induction	□Other: _____
□ Caesarean Delivery	□ Multiple Birth	
□ Difficult Delivery	□ Prolonged Labor	

Childhood Health

How would you describe your/the client's childhood health

□ Normal	□Ear Infections	□ Tubes in ears
□ Developmental Delay	□Head Injury	□ Other _____

Chronic/Serious Health Problem	No□ Yes□ if yes, explain _____
Significant Unusual Illness	No□ Yes□ if yes, explain _____
Significant Injury	No□ Yes□ if yes, explain _____
Hospitalization	No□ Yes□ if yes, explain _____
Surgery	No□ Yes□ if yes, explain _____

Substance Use/Abuse

Substances Used Currently Using	Age/First Use		Age/Last Use	Avg. Amt	Frequency	
□Alcohol	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Amphetamines/Speed	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Barbiturates	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Cocaine	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Hallucinogens	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Inhalants	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Marijuana	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Methamphetamines	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Nicotine/Cigarettes	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□PCP	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Prescription	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□
□Other_____	_____	_____	_____	per	□Day □ Week □ Month	No□ Yes□

Consequences of substance use

□ Assaultive Behavior	□ Interpersonal/Social Problems	□Suicidal Ideation
□ Blackouts	□ Legal Problems/Arrests	□Tolerance Symptoms
□ Educational Problems	□ Medical Problems	□Withdrawal Symptoms
□ Hangovers	□ Parental Neglect	□Other _____
□Hazardous Behavior	□ Sleep Disturbance	

Have you ever felt you should cut down on your drinking/drug use? No□ Yes□
Have people annoyed you by criticizing your drinking/drug use? No□ Yes□

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____
Have you ever felt bad or guilty about your drinking/drug use? No☐ Yes☐
Have you ever had a drink or used drugs first thing in the morning to steady you nerves or to get rid of a hangover? No☐ Yes☐

Treatment History

Have you ever received treatment for substance abuse/dependence? No☐ Yes☐ if yes, which have you received?
☐Outpatient Treatment _____ _____
_____ Helpful? No☐ Yes☐
Treatment Facility/Provider_____ Year _____
☐Inpatient Treatment _____ _____
_____ Helpful? No☐ Yes☐
Treatment Facility/Provider_____ Year _____
☐Stopped on Own ☐Other, explain_____

Current Living Situation

How would you describe your/the client's living situation?

☐Foster Home	☐Living Independently	☐Supported Independent Living
☐Group Home	☐Living Independently with others	☐Therapeutic Foster Care
☐Homeless	☐Living with Others in their Care	☐Other _____
☐Hospitalization	☐Nursing Home	
☐Jail	☐Shelter/mission	

Are there any housing issues that contribute to your/the client's current problem? No☐ Yes☐
☐Dependent on Others for Housing ☐Housing Dangerous/Deteriorating ☐Living Companions Dysfunctional ☐Homeless ☐Housing Overcrowded
☐Other_____

Who currently lives in the household
_____

Cultural History

What is your/the client's race/ethnicity?

☐ White/Caucasian	☐Black/African American	☐Other _____
☐American Indian/Alaskan	☐Hispanic/Latino	
☐Asian	☐Native Hawaiian/Pacific Islander	

What is your/the client's cultural identity? _____
Do you/the client celebrate/practice any particular cultural/ethnic traditions ☐No ☐Yes
If yes, explain _____

Spiritual History

What is your/the client's spiritual/religious identity? _____
Do you/the client currently participate in any spiritual/religious activities?
☐No ☐Yes If yes, explain _____

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

Recreational Activities

Are you/the client currently active in any community/recreational activities
☐No ☐Yes If yes, explain _____
If no, were you/the client formerly active in community/recreational activities?
☐No ☐Yes
What recreational activities and hobbies do you/the client participate?
_____

Social Support Network

How would you describe your/the client's social support?
☐Distance from Family ☐No Friends ☐Supportive
☐Few Friends ☐Substance-using Friends ☐Other _____

Do you/the client receive support/involvement for any of the following agencies?
☐No ☐Yes
☐Adult Probation ☐Head Start/Early Head Start ☐Pre-Release
☐AWARE ☐Health Department ☐Primary Health Care
☐Big Brothers/Big Sisters ☐Salvation Army ☐United Way
☐Dept. of Social Services ☐Other _____

Financial Status

How would you describe your/the family's current financial status and/or stressors?
☐No Current Financial Problems ☐Poverty/Below Poverty Income
☐Filing for Bankruptcy ☐Poor Credit History
☐Funding from SSI/SSD ☐Public Assistance
☐Other _____

Current Employment Information

What is your/the client's current employment status?
☐Full Time ☐Student ☐Supported/Sheltered
☐Part Time ☐Homemaker ☐Other _____
☐Self-Employed ☐Retired
☐Unemployed ☐Disabled/Unable to work

Are you/the client currently employed? ☐No ☐Yes
Current Employer:_____
Job Title/Position: _____
Time there: _____ month/years

Today's Date: ______________ Client Number ______________
Client Specialist who reviewed with client: __________________________

Treatment Information & History

Have you ever received mental health treatment before? ☐No ☐Yes

☐Case Management ☐School Based Mental Health
☐Counseling/Psychotherapy ☐Inpatient Treatment
☐Crisis Intervention ☐Other
☐Family Support Services

If above services were used, please answer the following:

Treatment Facility/Provider_____________________ Year_______ Length of Treatment______________ Contact Name____________________ Phone (___) ______________ Fax (____) ______________ Address ___________________________City ______________ State ____ Zip __________
Current Service ☐No ☐Yes

Treatment Facility/Provider_____________________ Year_______ Length of Treatment______________ Contact Name____________________ Phone (___) ______________ Fax (____) ______________ Address ___________________________City ______________ State ____ Zip __________
Current Service ☐No ☐Yes

Treatment Facility/Provider_____________________ Year_______ Length of Treatment______________ Contact Name____________________ Phone (___) ______________ Fax (____) ______________ Address ___________________________City ______________ State ____ Zip __________
Current Service ☐No ☐Yes

Treatment Facility/Provider_____________________ Year_______ Length of Treatment______________ Contact Name____________________ Phone (___) ______________ Fax (____) ______________ Address ___________________________City ______________ State ____ Zip __________
Current Service ☐No ☐Yes

Treatment Facility/Provider_____________________ Year_______ Length of Treatment______________ Contact Name____________________ Phone (___) ______________ Fax (____) ______________ Address ___________________________City ______________ State ____ Zip __________
Current Service ☐No ☐Yes

Treatment Facility/Provider_____________________ Year_______ Length of Treatment______________ Contact Name____________________ Phone (___) ______________ Fax (____) ______________ Address ___________________________City ______________ State ____ Zip __________
Current Service ☐No ☐Yes

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____

Treatment Facility/Provider_____ Year_____ Length of Treatment_____ Contact Name_____ Phone (___) _____ Fax (____) _____ Address _____City _____ State ____ Zip _____
Current Service □No □Yes

General Health

Overall, how would you describe your current health? □Excellent □Good □Fair □Poor

Who is your/the client's primary medical provider?

_____

Medical Symptoms/Problems

Do you have/have you had any of the following medical problems or symptoms?

□None	□Glaucoma	□Rheumatic Fever
□Allergies	□Head Injury	□Ringing in the Ears
□Alzheimer's Disease	□Dementia	□Seizures/Convulsions
□Anemia/Blood Disorder	□Asthma	□Autoimmune Disorder specify: __
□Cancer/Tumor	□Chronic Pain	□Diabetes
□Digestive Problems	□Fibromyalgia	□Heart Disease
□High Blood Pressure	□Kidney Problems	□Stroke
□ Other _____		

Medical Information

Are you currently taking any medications? □No □Yes

Medication Name_____ Dosage/Frequency _____Prescribed For _____ Time Began ___/____ Length Used _____ Dispensing Pharmacy - _____

Medication Name_____ Dosage/Frequency _____Prescribed For _____ Time Began ___/____ Length Used _____ Dispensing Pharmacy - _____

Medication Name_____ Dosage/Frequency _____Prescribed For _____ Time Began ___/____ Length Used _____ Dispensing Pharmacy - _____

Medication Name_____ Dosage/Frequency _____Prescribed For _____ Time Began ___/____ Length Used _____ Dispensing Pharmacy - _____

Today's Date: _____ Client Number _____
Client Specialist who reviewed with client: _____
Medication Name_____ Dosage/Frequency _____Prescribed For _____ Time Began ___/____ Length Used _____ Dispensing Pharmacy - _____

Medication Name_____ Dosage/Frequency _____Prescribed For _____ Time Began ___/____ Length Used _____ Dispensing Pharmacy - _____

Insurance Information

1st Carrier Name _____
Phone Number (___)_____
Group #: _____
ID #: _____

2nd Carrier Name _____
Phone Number (___)_____
Group #: _____
ID #: _____

FOR TMF STAFF: