THERESA WESTFALL
PATIENT SELF-REPORT: ADULT

Patient Name:_____ Age:___ Date:_____
Name of person completing this form (if not patient)_____
_____
1. Briefly describe the problem which brought you here today:_____
_____
_____

2. Are you having thoughts of hurting yourself or someone else? YES NO
If yes, please explain:_____
Have you ever had thoughts of hurting yourself or someone else? YES NO

PAST TREATMENT

3. Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? YES NO
If yes, when, where, and with whom?_____
Did you find past treatment helpful? YES NO

4. Are you currently under the care of a psychiatrist, therapist, or your primary care provider for a psychiatric problem? YES NO

5. Are you currently taking any psychiatric medications? YES NO
If yes, please list name(s) and dosage(s):_____
_____
Have you ever taken any psychiatric medications? YES NO
If yes, please list name(s) and dosage(s):_____
_____

MEDICAL PROBLEMS

6. Do you have any current medical problems? YES NO
If yes, please list:_____
_____
Have you ever had any significant medical problems? YES NO
If yes, please list:_____

7. Would you like information from today's visit communicated to your primary care provider or any other medical doctor? YES NO

8. Are you currently taking medication for medical problems? YES NO
If yes, please list name(s), dosage(s), and purpose:_____
_____

9. Do you have any allergies and/or medication allergies? YES NO

If yes, please list:_____

10. Do you have a history of head injury, seizures, or loss of consciousness?
YES NO Please explain:_____

11. (Women only) Are you pregnant? YES NO

12. Do you have any pain management issues? YES NO

SUBSTANCE ABUSE

13. Have you ever been treated for drug or alcohol abuse, or any other addictions? YES NO

14. Do you currently attend support groups? YES NO

15. Please circle any of the following that you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, methamphetamines/speed, methadone, LSD, PCP, Ecstasy, inhalants.

16. Have you ever experienced withdrawal symptoms? YES NO

17. Have you ever had a DUI? YES NO

LEGAL ISSUES

18. Do you have any current legal issues? YES NO

19. Are you currently on probation/parole? YES NO

20. Do you have a DFACS worker? YES NO

EMPLOYMENT/EDUCATION

21. Please circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired.

22. Are you currently on leave from work or seeking medical leave/disability?
YES NO

23. Please circle educational background: current student, did not complete high school, graduated high school, GED, some college, graduated college, advanced degree.

24. Did you experience difficulties in school? YES NO

FAMILY/RELATIONSHIPS

25. Please list anyone who lives in your home, his/her age, and relationship:
_____

26. Does anyone in your immediate or extended family have psychiatric, emotional, substance abuse, or behavioral problems? YES NO
If yes, please explain:_____
_____

27. Do you have a history of sexual or physical abuse? YES NO

28. Do you have any domestic violence issues? YES NO

29. What are your hobbies/interests?_____
_____

30. Is your support network: Good Moderate Poor

31. Do you have any difficulties or concerns about how you get along with other people? YES NO

32. Do you have difficulties with spiritual or religious matters?
YES NO

33. Do you have any sexual orientation/gender issues or concerns?
YES NO

TREATMENT ACCESS/MOBILITY

34. Are there any financial concerns that would affect your ability to access treatment? YES NO

35. Do you have access to transportation? YES NO

36. Do you have any disabilities, special needs, or other restrictions that may impact your treatment or access to treatment?
YES NO

Patient (or person completing this form) signature Date

I have reviewed and discussed this information with the patient.

Therapist Signature/Credentials Date