



counseling • support • compassion

CPFV Supplemental Packet

Name: _____ Date: _____

Please answer the following questions:

- Has anyone in your family been a victim of domestic violence? Yes No
- Have you been a victim of domestic violence? Yes No
- Does anyone in your family have trouble with anger? Yes No
- Do you have trouble with anger? Yes No
- Does anyone in your family use physical aggression? Yes No
- Do you use physical aggression? Yes No

In your relationship have you ever:

Insulted or swore at your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Interrupted your partner eating or sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Told your partner that they could not leave or see certain people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Withheld your partner from using the phone during an argument?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Verbally pressured your partner to have sex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatened to leave the relationship?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatened to withhold money, take away children or have an affair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Withheld sex as a form of manipulation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smashed, kicked or hit an object during an argument?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatened to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatened to hit your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatened to kill your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pushed, shoved, grabbed, or restrained your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Slapped your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drove recklessly to frighten your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threw an object at your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physically forced sex on your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Beat your partner up?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chocked your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Threatened your partner with a knife?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kicked your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Punched your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Partner Contact Release Form

Client Name: _____

Name of Incident Partner: _____

Incident Partner Phone Number: (H) _____ (C) _____

Incident Partner Address: _____

Is the incident partner your current partner? YES _____ NO _____

Are you living together? YES _____ NO _____

Is the incident partner the mother of your children? YES _____ NO _____

Name of Current Partner: (If different from incident partner) _____

Current Partner Phone Number: (H) _____ (C) _____

Current Partner Address: _____

Name of Former Partner with whom you have children: _____

Former Partner Phone Number: (H) _____ (C) _____

Former Partner Address: _____

The New Thresholds program requires that you allow Family Service to contact the individuals above for the following reasons:

1. To contact your (ex-) partner to introduce our programs and community services and encourage her to respond if she has questions or concerns.
2. To complete a pre and post group questionnaire as part of our program evaluation.
3. In the event that we have reason to fear for the safety of one of the above individuals.
4. To provide the date you begin attending New Thresholds group and the date you complete the program.

I authorize the New Thresholds program to disclose to the above named person(s) pertaining to my participation in the New Thresholds program, per the guidelines above.

Client Signature

Date

By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.

CPFV Staff Signature

Date

Client Information and History Form

Today's Date: _____

First Name: _____ Last Name: _____

Preferred Name: _____

In an emergency, we can contact: _____ Emergency phone number: _____

Briefly describe the concern(s) that brings you here today: _____

Have you received treatment for this problem in the past? Yes No

If yes, when, where, and with whom? _____

Educational History

Highest Grade Completed: _____ How well did you do academically? _____

Did you receive a High School Diploma GED HSED Post high school degree/training:

Degree: _____

Military History

Do you have military history? Yes No If yes, what branch of service?

Years of Service: _____ Discharge type: _____

Employment

Current Employer: _____ Type of work / Job Title: _____

How long have you worked there? _____ Are you satisfied with your job? Yes No

What do you like about your job? _____

What do you dislike about your job? _____

Do you have financial problems/concerns? Yes No

Would you like information about financial counseling? Yes No

Household Information: Please list below family and other household members:

<i>Name</i>	<i>Gender</i>	<i>Age</i>	<i>How related to you?</i>	<i>Living with you?</i>	<i>Adult: Employer & Occupation Child: School & Grade</i>
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History

Who raised you? _____

Describe your relationship with them: _____

Please list the names and ages of the members of your childhood family.

<i>Name</i>	<i>Gender</i>	<i>Age</i>	<i>Describe relationship</i>

Does anyone in your family have a problem with alcohol or drug use? Yes No

Does anyone in your family have a mental health problem? Yes No

If yes to any above, please explain: _____

Legal History

Have you ever been in trouble with the law? Yes No

Are you currently involved in the criminal justice system? Yes No

If yes, please list name of offense, date, and sentence information. _____

List any previous arrests. (Include date, offense, and sentence.) _____

Personal History

Please explain any special considerations due to age, gender, sexual orientation, disability, culture, race, ethnicity, or religion:

Suicide Evaluation

Do you think about harming yourself or ending your life? Yes No

If yes, do you have a plan? Please explain.

Have you ever attempted suicide? Yes No

If yes, please explain. Include date, method, and any treatment you received as a result.

Do you think about harming someone else or ending their life? Yes No

If yes, towards whom? And do you have a plan? Please explain.

Have you ever intentionally harmed or attempted to harm another person? Yes No

If yes, whom? Also, please explain.

Current Stressors - Please check all that apply to your current situation:

Comments

Therapist Comments

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Comments</i>	<i>Therapist Comments</i>
Relationship / marriage	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Family	<input type="checkbox"/> Yes <input type="checkbox"/> No		
School / Job	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Finances	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grief due to loss of a loved one	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Situational changes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sexual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gambling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Current Symptoms

<i>Symptom/problem description</i>	<i>Currently a problem (x)</i>	<i>How long has it been a problem?/comments</i>	<i>Therapist Comments</i>
Sadness	<input type="checkbox"/>		
Irritability / anger	<input type="checkbox"/>		
Weight change	<input type="checkbox"/>		
Change in appetite	<input type="checkbox"/>		
Sleep pattern changes	<input type="checkbox"/>		
Guilt feelings	<input type="checkbox"/>		
Feeling hopeless	<input type="checkbox"/>		
Feelings of worthlessness	<input type="checkbox"/>		
Difficulty concentrating	<input type="checkbox"/>		
Difficulty making decisions	<input type="checkbox"/>		
Loss of interest in activities once enjoyed	<input type="checkbox"/>		
Decreased sexual drive	<input type="checkbox"/>		
Fatigue, loss of energy	<input type="checkbox"/>		
Poor self-esteem	<input type="checkbox"/>		
Memory problems	<input type="checkbox"/>		
Depression	<input type="checkbox"/>		
Thoughts of suicide or death	<input type="checkbox"/>		
Thoughts of harming another	<input type="checkbox"/>		
Worrying a lot	<input type="checkbox"/>		
Feeling anxious	<input type="checkbox"/>		
Fear of losing control	<input type="checkbox"/>		
Feelings of panic	<input type="checkbox"/>		
Feelings that you're having a heart attack	<input type="checkbox"/>		
Numbness or tingling	<input type="checkbox"/>		
Fear of social situations	<input type="checkbox"/>		
Seeing or hearing things that others do not	<input type="checkbox"/>		
Episodes of times you can't remember	<input type="checkbox"/>		
Thoughts that bother you	<input type="checkbox"/>		
Beliefs that others do not agree with	<input type="checkbox"/>		
Behaviors that bother you	<input type="checkbox"/>		

<i>Symptom/problem description cont.</i>	<i>Currently a problem (x)</i>	<i>How long has it been a problem?/comments</i>	<i>Therapist Comments</i>
Difficulty being alone	<input type="checkbox"/>		
Difficulty in relationships	<input type="checkbox"/>		
Self-injury behavior	<input type="checkbox"/>		
Risky or reckless behavior	<input type="checkbox"/>		
Feelings of unreality / being detached from self	<input type="checkbox"/>		
Repetitive behaviors (such as hand-washing, ordering, counting, or checking)	<input type="checkbox"/>		
Recurring dreams	<input type="checkbox"/>		
Flashbacks after an event	<input type="checkbox"/>		
Distinct periods of inflated self-esteem, excessive spending, goal-directed activity, or racing thoughts	<input type="checkbox"/>		
Persistent difficulty with fidgeting, feeling on the go, interrupting others, talking too much, or having impatience	<input type="checkbox"/>		
Persistent difficulty with forgetfulness, sustaining attention, or completing tasks	<input type="checkbox"/>		
Less effective at home, school, or work	<input type="checkbox"/>		

Trauma History

Have you experienced any of the following?

Emotional abuse Yes No Sexual abuse Yes No Physical abuse Yes No
 If yes, please explain:

Have you ever witnessed verbal aggression or physical fighting? Yes No
 If yes, please explain:

Have you ever experienced trauma not explained above? Yes No
 If yes, please explain:

Who do you rely on most when you need help? _____

Any recent changes in support system? _____

Alcohol / Other Drug Use

Please check all that apply.

		<i>Comments</i>	<i>Therapist Comments</i>
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had treatment for alcohol or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use drugs? If yes, please indicate which drug(s), amount, and how often.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever thought you drink or use drugs too much?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has anyone ever expressed concern about your drinking or drug use? If yes, indicate who and why.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever felt remorseful or embarrassed about your usage?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has drinking or drug use created unhappiness in your home, relationships, or marriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had any legal difficulties or traffic incidents as a result of your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has work, school, or other interests/activities been affected by your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use drugs or alcohol to relax, reduce tension, or escape from problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had health problems that were related to your alcohol or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever experienced any black outs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had difficulty controlling or limiting your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever felt distracted or had obsessive thoughts of drinking or using drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Medical History

Do you have or have you ever had any of the following:

		<i>Any comments?</i>	<i>Therapist comments</i>
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High or low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have or have you ever had any of the following:

Any comments?

Therapist comments

Digestive problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Incontinence / bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Liver disease (e.g. hepatitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Neurological problems (e.g. seizures)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sexual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Miscarriage / abortion	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Currently pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe		

Please list any other medical concerns or conditions:

Please list any medications you are currently taking. Also, please state what they are used for.
(Please include herbal, over-the-counter, & prescribed items)

Prescription name (or herbal name):

For:

Prescribed by:

<i>Prescription name (or herbal name):</i>	<i>For:</i>	<i>Prescribed by:</i>

Have you taken any psychiatric medications in the past? Yes No If yes, please list:

If yes, were they effective? _____

Primary Care - Physician Information

Physician's name: _____

Name of practice: _____

Phone #: _____

How would you rate your overall health?

- Excellent Very good Good Not very good Poor

How often do you worry about your health?

- Never Rarely Occasionally Often Always

Mental Health History

Have you received counseling before? Yes No

If yes, when, where, and with whom?

What type of counseling services did you receive?

Have you been to Family Service before? Yes No

If yes, when, with whom, & what services were provided?

Are you interested in receiving information about other services & programs that Family Service can provide? Yes No

Treatment Goals

What changes would you like to see as a result of the services you receive? Beginning with the most important goal, please indicate three goals.

1. _____

2. _____

3. _____

Please describe the specific changes in your life that will be signs that things are improving:

What are some barriers that have interfered with change so far, including any personal weaknesses or other limitations?

Please describe your personal strengths, assets, and accomplishments, including those you have used to help you overcome previous difficulties.

Please Stop When You Get Here 😊

Completed by Family Service Staff
Intake Assessment

Presenting Problem/ Symptoms:

Client Strengths and Supports

Recent Changes to Support System:

Mental Status Evaluation

Appearance	<input type="checkbox"/> appropriate	<input type="checkbox"/> well-groomed	<input type="checkbox"/> inappropriate	<input type="checkbox"/> disheveled	<input type="checkbox"/> bizarre
Orientation	<input type="checkbox"/> fully-oriented	<input type="checkbox"/> not fully-oriented (describe: _____)		<input type="checkbox"/> normal	<input type="checkbox"/> impaired
Speech	<input type="checkbox"/> relevant	<input type="checkbox"/> normal	<input type="checkbox"/> logical	<input type="checkbox"/> slow	<input type="checkbox"/> incoherent
	<input type="checkbox"/> loud	<input type="checkbox"/> precise	<input type="checkbox"/> soft		<input type="checkbox"/> rapid/pressured
Affect	<input type="checkbox"/> appropriate	<input type="checkbox"/> inappropriate	<input type="checkbox"/> flat	<input type="checkbox"/> constricted	<input type="checkbox"/> agitated <input type="checkbox"/> tearful
Thought Process	<input type="checkbox"/> intact	<input type="checkbox"/> abstract	<input type="checkbox"/> loose associations		<input type="checkbox"/> vague <input type="checkbox"/>
	<input type="checkbox"/> blocked	<input type="checkbox"/> concrete	<input type="checkbox"/> circumstantial	<input type="checkbox"/> flight of ideas	<input type="checkbox"/> tangential
Thought Content	<input type="checkbox"/> normal	<input type="checkbox"/> paranoia	<input type="checkbox"/> obsessions	<input type="checkbox"/> other: _____	
	<input type="checkbox"/> confusion	<input type="checkbox"/> delusions	<input type="checkbox"/> hallucinations		
Intelligence	<input type="checkbox"/> above average	<input type="checkbox"/> average	<input type="checkbox"/> below average		
Mood	<input type="checkbox"/> appropriate	<input type="checkbox"/> sad	<input type="checkbox"/> anxious	<input type="checkbox"/> panicky	<input type="checkbox"/> depressed
	<input type="checkbox"/> angry	<input type="checkbox"/> irritated	<input type="checkbox"/> euphoric	<input type="checkbox"/> despairing	<input type="checkbox"/> bored
Motor Activity	<input type="checkbox"/> normal	<input type="checkbox"/> overactive	<input type="checkbox"/> under-active	<input type="checkbox"/> other: _____	
	<input type="checkbox"/> aggressive	<input type="checkbox"/> compulsive	<input type="checkbox"/> seductive		
Attitude	<input type="checkbox"/> cooperative	<input type="checkbox"/> uncooperative	<input type="checkbox"/> guarded	<input type="checkbox"/> suspicious	<input type="checkbox"/> belligerent
Reliability	<input type="checkbox"/> appears to be truthful		<input type="checkbox"/> appears to minimize	<input type="checkbox"/> appears to exaggerate	
Insight	<input type="checkbox"/> above average	<input type="checkbox"/> average	<input type="checkbox"/> limited	<input type="checkbox"/> absent	<input type="checkbox"/> unable to assess
Judgment	<input type="checkbox"/> good	<input type="checkbox"/> poor	<input type="checkbox"/> unable to assess		
Harm to Others Thought/Intent	<input type="checkbox"/> absent	<input type="checkbox"/> present	If present, safety plan		
Suicide Risk: Thought/Intent	<input type="checkbox"/> absent	<input type="checkbox"/> present	If present, complete suicide safety plan		

AODA Information - Note: AODA treatment requires AODA specialty or a referral to an AODA specialist

Primary AODA treatment needed: Yes No

Client referred elsewhere for AODA Name: _____

Client referred to internal expert: Name: _____

Purpose of internal or external referral:

Other Referrals

Diagnostic Criteria (DSM-5):

Principal Diagnosis	
Other	
Other	

Important psycho-social or contextual factors:

Disability or medical considerations:

Case Conceptualization:

Consultant / Supervisor recommendations (trainees/supervisory protocol):

THERAPIST’S ATTESTATION: *“My signature below indicates that I have completed a mental health assessment sufficient to determine the client’s need for outpatient treatment and I have reviewed and discussed with the client all information collected and contained herein”.*

Therapist Signature

Date

Signature of Supervisor (trainees/supervisory protocol)

Date

Date of initial staffing: _____