Safe at Home Questionnaire Revised

Instructions: Please check the box that **BEST** describes how much you agree or disagree with each statement in the list below.

Item Statement	I STRONGLY AGREE (1)	I AGREE (2)	I DON'T AGREE OR DISAGREE (3)	I DISAGREE (4)	I STRONGLY DISAGREE (5)
The last time I lost control of myself, I realized that I have a problem. (1-C)					
I do not believe that I will return to my old ways of losing control. (2-M)					
I try to listen carefully to others so that I don't get into conflicts anymore. (3-P/A)					
It feels good to finally face how I've been messing up my life. (4-C)					
It's no big deal if I lose my temper from time to time. (5-P)					
I handle it safely when people get angry with me. (6-P/A)					
Sometimes I find that it is still very hard for me to avoid my old ways of treating my partner. (7-*)					
I have a problem with losing control of myself. (8-*)					
I want to do something about my problem with conflict. (9-C)					
I want help with my temper. (10-C)					
I'll come to groups, but I won't talk. (11-P)					
I am actively keeping my cool when my partner(s) and I have conflicts. (12-P/A)					
I need to change before it's too late. (13-C)					
There's nothing wrong with the way I handle situations, but I get into trouble for it anyway. (14-P)					
Even though I get angry I know ways to avoid losing control of myself. (15-P/A)					
I really am different now than I was when conflicts were a problem for me. (16-M)					
I guess I need help with the way I handle things. (17-C)					
It'll cost me plenty to get help. (18-P)					

I have been successful at keeping myself from going back to my old ways of acting when I have conflicts with my partner. (19-M)					
If my partner doesn't like the way I act, it's just too bad. (20-P)					
Some of what I see and hear about people being abusive seems to apply to me. (21-C)					
When I feel myself getting upset, I have ways to keep myself from getting into trouble. (22-P/A)					
I'm sick of screwing up my life. (23-C)					
I try to talk things out with others so that I don't get into conflicts anymore. (24-M)					
I am sure that I will never return to my old ways of treating my partner(s). (25-M)					
It's my partner's fault that I act this way. (26-P)					
It's okay that I got into trouble because it means that now I'm getting help. (27-*)					
It's becoming more natural for me to be in control of myself. (28-P/A)					
I'd get help if I had more free time. (29-P)					
I have a plan for what to do when I feel upset. (30-P/A)					
Recent changes that I have made probably won't last. (31-*)					
It's time for me to listen to the people telling me that I need help. (32-C)					
I know the early cues for when I'm losing control. (33-M)					
I need to control my partner. (34-P)					
Anyone can talk about changing old ways of acting in relationships. I am actually doing it. (35-M)					

36. Please check the box for the description that best describes where you think you are, today, in your efforts to change the way you behave with your partner(s). (Check only one box)

- ☐ I am not really making any changes
- ☐ I am thinking about making changes in the future
- ☐ I am getting ready to make changes or I have made some changes already
- ☐ I have made some important changes and I have more to do
- ☐ I have made the changes I needed to make and now I have to keep up the good work

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Partner Contact Release Form

Client Name: _____

Name of Incident Partner: _____
Incident Partner Phone Number: _____
Incident Partner Email: _____
Incident Partner Address: _____
Is the incident partner your current partner? YES_____ NO_____
Are you living together? YES_____ NO_____
Is the incident partner the parent of your child(ren)? YES_____ NO_____

Name of Current Partner (if different from incident partner): _____
Current Partner Phone Number: _____
Current Partner Email: _____
Current Partner Address: _____

Name of Former Partner with Whom You Have Children: _____
Former Partner Phone Number: _____
Former Partner Email: _____
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 them to respond if they have questions or concerns.
2. If we have reason to fear for the safety of one of the above individuals.
3. To provide the date you begin attending the 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

_____ _____
CPFV Staff Signature Date

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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:

Name	*Gender*	*Age*	*How related to you?*	*Living with you?*	*Adult: Employer & Occupation Child: School & Grade*
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Family History

Who raised you? _____

Describe your relationship with them: _____

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

Name	*Gender*	*Age*	*Describe relationship*

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***
Relationship / marriage	☐ Yes ☐ No		
Family	☐ Yes ☐ No		
School / Job	☐ Yes ☐ No		
Finances	☐ Yes ☐ No		
Grief due to loss of a loved one	☐ Yes ☐ No		
Situational changes	☐ Yes ☐ No		
Sexual problems	☐ Yes ☐ No		
Gambling	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		

Current Symptoms

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

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

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.

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

Medical History

Do you have or have you ever had any of the following:		***Any comments?***	***Therapist comments***
Allergies	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No		
High or low blood pressure	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		

Do you have or have you ever had any of the following:		***Any comments?***	***Therapist comments***

Digestive problems	☐ Yes ☐ No		
Headaches	☐ Yes ☐ No		
Head injury	☐ Yes ☐ No		
Hearing problems	☐ Yes ☐ No		
Heart disease	☐ Yes ☐ No		
Incontinence / bed wetting	☐ Yes ☐ No		
Kidney problems	☐ Yes ☐ No		
Liver disease (e.g. hepatitis)	☐ Yes ☐ No		
Neurological problems (e.g. seizures)	☐ Yes ☐ No		
Sexual problems	☐ Yes ☐ No		
Thyroid problems	☐ Yes ☐ No		
Vision problems	☐ Yes ☐ No		
Miscarriage / abortion	☐ Yes ☐ No		
Currently pregnant	☐ Yes ☐ No ☐ 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:***

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

If yes, were they effective?

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