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

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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

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Updated: 9/6/19

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: _____