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First and last name:	Date of birth:	Date completed:
Address:	City:	State:
Insurance type:	Insurance ID number:	Insurance group number:
Age:	Sex: male or female	Sexual orientation:
Race/ethnicity:	Religion or beliefs:	Pronoun (i.e. Mr., Mrs., Ms., he/she, etc.):
County of probation:	Probation agent:	Probation phone number:
Social Service (SS) Provider:	SS Provider Phone number:	Educational level:
Financial Status: Well Fair Struggling	Relationship status (#): Single _____ Married ____	Partnership ______ Widowed ____ Divorced ___

What I am struggling with is: (circle all that apply)

Depression	Anxiety	Sleep disturbance
Appetite disturbance	Loss of motivation	Fear
Muscle tension	Irritability	Racing thoughts
Paranoia	Visual hallucinations	Psychotic behaviors
Auditory hallucinations	Relationship issues	Financial issues
Educational issues	Housing issues	Nutrition issues
Weight gain	Parenting issues	Substance use issues
Communication issues	Traumatic experience	Abuse survivor
Abused another	Anger outbursts	Legal issues
Codependent	Emotionally detached	Grief/loss
Chronic pain	Learning disability	Identity issues
Sexual issues	Impulsive behaviors	Compulsive behaviors
Gambling issues	Eating disorder	Dissociation
Nightmares	Panic attacks	Negative outlook on life

Self-injurious behaviors: None Past Present	Suicidal ideations: None Past Present	Suicidal attempts: None Past Present
Veteran/Military related issues	Homicidal ideations: None Past Present	Aggressive behavior: None Past Present
Lying	Attention issues	Hyperactivity
Concentration issues	Health issues	Safety concerns

Please complete the following thoroughly:
Medications I am taking: ____
Health issues: ____
Developmental delays:____
Primary clinic/provider:______________________Date of last visit:____________
Dental provider:___________________________Date of last visit:____________
Eye care provider:__________________________Date of last visit:____________
Dental or vision concerns: Yes No Unsure
History of head injuries: Yes No Unsure
Veteran: Yes No
History/Present commitment through the county: Yes No
Biological children (include ages):_______________________________________
____
Other children & ages (i.e. step-children, adopted, foster): ____________________
____
Values and traditions: ____
Past and pending legal charges: ____
____
____

<u>My history of mental health services includes:</u> (circle all that apply)

Outpatient therapy	Partial hospitalization	Hospitalization
Outpatient CD treatment	Inpatient CD treatment	Detox services
ARMHS	TCM	Case Management
Commitment	ACT	Social Worker

Reason for seeking therapy: ____
What I want to get from therapy is: ______________________________________
____

CAGE AID

Have you ever felt you ought to cut down on your drinking or drug use?	YES	NO
Have people annoyed you by criticizing your drinking or drug use?	YES	NO
Have you felt bad or guilty about your drinking or drug use?	YES	NO
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	YES	NO

WHODAS 2.0 12-item self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please **circle** only one response.

In the past 30 days, how much difficulty did you have in:

1. Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme/Can't do
2. Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme/Can't do
3. Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme/Can't do
4. How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme/Can't do
5. How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme/Can't do
6. Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme/Can't do
7. Walking a long distance such as a kilometre [or equivalent]?					
8. Washing your whole body?	None	Mild	Moderate	Severe	Extreme/Can't do
9. Getting dressed?	None	Mild	Moderate	Severe	Extreme/Can't do
10. Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme/Can't do
11. Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme/Can't do
12. Your day-to-day work?	None	Mild	Moderate	Severe	Extreme/Can't do

13. Overall, in the past 30 days, how many days were these difficulties present? ____________
14. In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition? ___________
15. In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? ____________