ADULT Initial Screening Form

Client Name:____

Cultural/Ethnic Background: African American/Black   Asian   Caucasian/White   Hispanic
Native American/First Nation   Native Hawaiian/Pacific Islander
Other______________________

Current Living Situation: (Please check best description and provide name):

Husband   Wife   Boyfriend   Girlfriend   Domestic Partner   Parent(s)

Emergency Contact Name:____ Telephone:__________________________________

Other Adult in the home:____ Relationship:_________________________________

Other Adult in the home:____ Relationship:_________________________________

Child in the home:____ Age:____ Relationship:_________________________________

Child in the home:____ Age:____ Relationship:_________________________________

Child in the home:____ Age:____ Relationship:_________________________________

We are asking the following questions to get an understanding of your physical and emotional health. This is critical in determining your needs. Please check all answers that apply.

1. What is your primary concerns leading to referral?

Depression/sadness
Suicide thoughts
Suicide attempt(s)
Self-injury
Grief/loss
Divorce/separation
Adjustment problems
Anxiety
Social contact avoidance
Obsessive compulsions
Impulsive behaviors
Hyperactive
Sexual acting out
Somatic complaints
Sleep disturbance
Eating disorder
Job/academic problems
Sexual assault
Sexual abuse/incest
Trauma
Cruelty to animals
Physical aggression
Threat to life of others
Poor peer interactions
Poor self-esteem
Family issues
Relationship problems
Police contact/legal problems
Alcohol/substance abuse
Addiction issues
Domestic violence
Verbal/emotional abuse
Victim of theft/stealing
Strange behavior

Other: ____

2. Over the past year which of the following has occurred?

Been diagnosed with a serious medical condition
Significant other diagnosed with a serious medical condition
Suffered a loss of a loved one
Difficulty with concentration/focus
Sleep Disturbance
Tension and difficulty relaxing
Excessive need for reassurance from others
Over-dependence on others
A lot of self-consciousness
Major life changes
Excessive weight: gain loss
Battled an addiction

3. Have you recently demonstrated any of the following (while not on any non-prescribed drugs)?

Heard voices talking to you (hallucinations)
Had bizarre or very unusual thoughts
Exhibited odd behaviors
Difficulty with memory
Wandering the house at night

4. Do you have any medical conditions? If so, please describe:

5. Are you currently taking any medications? Yes No

(If yes, fill in below; please attach a separate list if more space is needed.)

Primary Care Physician:____ Psychiatrist:________________________________

Medications/Dosage/Frequency	Condition	Prescribing Physician

6. Are you currently allergic to anything (including medications)? Yes No ***(If yes fill in below.)***

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____

7. Stress situations that have been present <u>in the past year</u>?

Death | Financial hardship | Family violence | Family member illness/accident

Divorce/separation | Remarriage | Frequent arguments | High frequency moving

Custody problems | Visitation | Job change(s) | Legal issues

Other: ____

8. Have you had any of the following legal actions?

Been detained or arrested

DCFS/CPS involvement

Court Hearings:____

Been on parole/probation

9. <u>Physical/ Mental Health/ Educational Services</u>

Previous Treatment: | **If yes, where, when, reason (if applicable)?**

Outpatient mental health services ____

Psychiatric evaluation/ medication management ____

Inpatient psychiatric hospitalization or crisis center ____

Mental health residential treatment ____

Alcohol or substance abuse treatment ____

Foster care or group home ____

Special education ____

Medical hospitalizations ____

10. Is there a family history of the following?

	Mothers' Side	Fathers' Side
Manic depression/Bipolar		
Depression		
Suicide		
Drug abuse		
Alcohol abuse		
Developmental delay		
Psychosis		
Sexual abuse		
Anxiety		
Other:______________________		

	Mothers' Side	Fathers' Side
Physical abuse		
Hyperactivity		
Psychiatric medication		
Obsessive Compulsive Disorder		
Panic disorder		
Gambling		
Convicted of crime		
Prison term		
Hospitalization for mental illness		

11. Have you ever made any suicide attempts?

No Yes If so, ages(s)____

12. Are there any firearms or weapons in the home?

No Yes (please describe)____

Prenatal/ Neonatal (*Birth/Infancy*) History (Please answer the best to your ability)

1. **Your birth mother (check all that apply)**
   - Unknown
   - Smoked during pregnancy
   - Have Rh factor incompatibility
   - Used drugs during or before pregnancy
   - Bled during the pregnancy
   - Used alcohol during pregnancy
   - Have medical or emotional problems during pregnancy

2. **Were there any known complications prior to and at birth? If so, please describe:**

Early Childhood History *(0-3 Years)* (Please answer the best to your ability)

1. **Were you hospitalized? If yes:**

   Age___ Reason______________________________

   Age___ Reason______________________________

   Age___ Reason______________________________

   Age___ Reason______________________________

2. **Did you sustain any significant head injuries? If yes, please describe:**

3. **Did you have (check all that apply):**
   - Unknown
   - Speech disturbances
   - Hearing problems
   - Arching/stiffening when held
   - Hyperactivity
   - Clumsiness
   - Vision problems
   - Difficulty being consoled
   - Special Education
   - Act as if difficulty understanding spoken language
   - Development delays? If yes, describe:

4. **Were there serious marital/ couple/ family problems during this period?** Unknown Yes No

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Preschool/ Childhood History/ Adolescent History (*3-17 Years*) (Please answer the best to your ability)

1. **1. Were you hospitalized? If yes:**

   Age___ Reason______________________________

   Age___ Reason______________________________

   Age___ Reason______________________________

   Age___ Reason______________________________

   Age___ Reason______________________________

2. **Did you have any medical conditions? If yes, please describe:**

3. **As a child were you (check all that apply):**
   - Overly aggressive
   - Accident prone
   - Inattentive
   - Clumsy
   - Hard to discipline
   - Withdrawn
   - Unhappy
   - Anxious
   - Affectionate
   - Serious marital/couple/family problems
   - Special Education (IEP)
   - Speech problems
   - Victim of bullying
   - Been retained
   - Peer/sibling problems
   - Problems with authority
   - Substance abuse
   - Sexual acting out
   - Problems with the law
   - Other ______________________________

______________________________ Signature

______________ Date

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _______

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _______

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _______

4. Did you **often or very** often feel that…
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _______

5. Did you **often or very often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _______

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _______

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something else?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _______

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _______

9. Was a household number depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _______

10. Did a household member go to prison?
    Yes No If yes enter 1 _______

Now add up your "Yes" answers. **This is your ACE Score:** _______