

**Macomb Family Services, Inc.
Client Self Report**

Case No: _____

Client Name: _____ Date: _____

Client Social Security #: _____

Form completed by (if someone other than client) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home) _____ (Work) _____ DOB ___/___/___ Age _____

May the agency/therapist contact you at home? Yes ___ No ___ Work? Yes ___ No ___

Why are you requesting counseling? What do you see as the main issue?

Symptom Checklist: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sleep related disorders |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Impulse control | <input type="checkbox"/> Past substance use/abuse |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Lack of interest in activities | <input type="checkbox"/> Current substance use/abuse |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Suicidal/Homicidal ideations |
| <input type="checkbox"/> Difficulty adjusting to
life changes | <input type="checkbox"/> Loss/Grief | <input type="checkbox"/> Tearful |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Mania | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Distinctive behaviors | <input type="checkbox"/> Nightmares/Night terrors | <input type="checkbox"/> Worrisome |
| <input type="checkbox"/> Fire-setting | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Oppositional behaviors | |

If you have other symptoms not listed above, please describe.

Have any of the above symptoms been present for more than a year?

What would you like to accomplish during treatment?

COUNSELING AND PRIOR TREATMENT

Please list all previous treatment experiences.

Type of Treatment	Yes	No	Date (month/year)	# Of times	Where	Outcomes
Counseling/Psychiatric Treatment						
Alcohol/Drug Treatment						
Hospitalizations						
Self-help groups: AA, Al-Anon, ACOA, Overeaters, Other(s) _____						

Have you experienced any of the following?

- | | |
|--|---|
| Current Past No
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe childhood illnesses
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physical Abuse
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emotional Abuse
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neglect
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Protective Service Involvement | Current Past No
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems in school
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trauma from crime
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emotional difficulty due to divorce
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sibling conflicts
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Parenting problems
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physical / Domestic violence |
|--|---|

Describe Incident	When

Have you ever experienced any suicidal thoughts? Yes No Current Past

Age: _____

If yes, please describe; and if they are current, please provide some details.

Have you ever attempted suicide? Yes No Current Past Age: _____

If yes, list how many times, the most recent date, and the method (s) used.

Have you experienced any homicidal thoughts? Yes No Current Past Age: _____

If yes, please describe; and if they are current, please provide some details.

Have you ever acted on these thoughts? Yes No

If yes, list how many times, the most recent date, and the method (s) used.

Have you ever assaulted anyone? Yes No

If yes, list how many times, and include the dates and how the assault(s) happened.

Has a family member or close friend of yours ever attempted or committed suicide? Yes No

Family Member or Friend	Attempted / Committed	When

PHYSICAL & MEDICAL HISTORY

Do you have any history of head injuries? Yes No If yes, at what age: _____

I currently receive treatment for physical symptoms, pain, and/or an impairment or disability. Yes No

Do you have any known drug or other allergies? Yes No

If Yes, please list:

Last physical exam: Date: _____ Performed by: _____

Address of Personal Physician _____

_____ Telephone No. _____

How would you describe your health? Excellent Good Fair Poor

Have you ever had any seizures? Yes No If Yes,
when _____

Have you ever had surgery? Yes No If Yes, when: _____

Are you pregnant? Yes No If Yes, when is your expected due date:

Do you have access to medical insurance? Yes No

Please list any past or present illnesses or medical conditions (Type of Illness or Condition)	Are you currently being treated?	
	YES	NO

Have you experienced or been treated for any of the following problems?

- Blackouts
- Heart Disease
- Thyroid Problems
- Cancer
- High or Low Blood Pressure
- Seizures
- Migraines
- Kidney Disease
- TB
- Diabetes
- Liver Disease
- Weight Changes
- DT's
- Pancreatis
- Other

If Other, please list: _____

Please list your current medications, including over the counter (OTC) medications.

Medication	Dosage	RX Date	Doctor	Reason
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FAMILY INFORMATION

	Name	Current Age	Deceased		Your age then	Living with you	
			Yes	No		Yes	No
Mother							
Father							
Spouse							
Children							
Siblings							

Please list anyone else living with you.

	Age	Relationship to you

Has anyone in your family ever been diagnosed with a mental illness? Yes No

Family Member	Type of Illness	When

Marital Status:

- Single
- Unmarried & living with significant other
Length of time _____
- Married
Length of time _____

- Divorced
Length of time _____
- Widowed
Length of time _____

Other Marital Information: (check all that apply)

Total number of marriages _____
 Separated
Length of time _____

Divorce in progress
 Annulment
Length of time _____

Assessment of current relationship: Good Fair Poor N/A

Do you have any conflicts with family members? Yes No If yes, please explain.

Parental Information:

Parents legally married Mother remarried: Number of times _____
 Parents ever separated Father remarried: Number of times _____
 Parents ever divorced I was adopted and/or placed in foster homes.

Please list any other information that your therapist may find helpful in treating you. For example, were you raised outside the home by grandparents, other family members, or foster homes, etc?

Do you have family members or close friends with an alcohol or drug problems? Yes No

Have you ever lived with someone who has an alcohol/substance abuse problem? Yes No

Do you wish to have any family members or close friends involved in your treatment? Yes No

RECREATION & LEISURE

Has your activity level changed in the last 6 months? Yes No

If yes, please describe: _____

Which of the following activities do you participate in on a regular basis?

Daily/ Weekly/ Monthly

Art
 Music
 Crafts
 Outdoor activity
 Church activity

Daily/ Weekly/ Monthly

Books/Films
 Physical Fitness
 Diet/Health
 Sports
 Other _____

Do you or any family member have a gambling problem? Yes No

Do you ever gamble more than you intended? Yes No

If yes please describe _____

SPIRITUAL & RELIGIOUS MATTERS

Do you consider yourself a spiritual person? Yes No

If yes to the above what religion were you raised in and what religion to you practice now?

Do you have any spiritual/religious issues that may affect your treatment? Yes No

If yes, explain _____

EMPLOYMENT

Are you satisfied with your current job? Yes No

What is the longest period of time that you have held a job? _____

Check all that apply

- Employed full-time
- Employed part-time
- Currently unemployed
- Laid off
- Retired
- Homemaker
- Medical Disability (Type) _____
- Suspended

Are you experiencing financial problems that are impacting your mental health issues?

Yes No If yes, explain _____

For purposes of funding and setting the service fees, please complete the following.

Family Member	Employer	Dates of Employment	Annual Income
Client			\$
Client's Spouse			\$
Other Sources of Income			\$
Total Household Income			\$

CULTURAL / ETHNIC INFORMATION

What is your cultural or ethnic background? _____

Is your cultural or ethnic background a significant part of your life? Yes No

If yes, explain _____

Do you have any concerns how your culture or ethnicity may affect your therapy? Yes No

If yes, explain _____

EDUCATION

- Earned high school diploma (year) _____
- Did not complete high school. Last grade completed _____
- Currently attending college or university: year _____.
- Major or field of study _____.
- Earned G.E.D. (year) _____

Vocational training Currently enrolled Training completed, Specialty: _____

Have you earned a degree or professional or technical certification? Yes No

Please list _____

Are you interested in furthering your education? Yes No

Do you have special circumstance regarding your education? For example, please comment if you have had a history of ADD/ADHD, learning disabilities, gifted program, alternative or special education, etc.

MILITARY

Military experience? Yes No When? _____ Where? _____

Combat experience? Yes No When? _____ Where? _____

Branch _____ Discharge Date _____

Date drafted _____ Type of discharge _____

Date enlisted _____ Rank at discharge _____

LEGAL

Have you been referred to **MFS** by Court Order? Yes No

Have you been referred to **MFS** by DHS? Yes No Worker's Name _____

Name & Address of court (if applicable) _____

Have you ever been, or are you now involved in any of the following legal or court proceedings?

Drunk Driving Yes No Currently on Probation/Parole Yes No

Assault Crime Yes No Civil Case Yes No

Workman's Comp Yes No Juvenile Court Yes No

Bankruptcy Yes No DHS Yes No

If yes please complete the following:

Type of Case, charge, arrest, etc.	Date	Where (city)	Result

If yes, explain _____

COMPULSIVE BEHAVIOR

Have you experienced any of the following behaviors that you would consider compulsive or addictive.

- Cleaning
- Internet
- Shopping
- Eating
- Pornography
- Work
- Gambling
- Sex
- Other

Comments:

SOCIAL

Describe how you relate to other people (e.g., easily, shy, leader, follower, outgoing, etc.)

Who are the (3) people you feel closest to? _____

Do you isolate yourself from others? Yes No If yes, please explain:

Do your social activities include the use of drugs or alcohol? Yes No If yes, please explain:

Sexual Orientation:

- ___ Heterosexual (attracted to opposite sex)
- ___ Bisexual (attracted to both sexes)
- ___ Homosexual (attracted to the same sex)
- ___ Confused / Not sure

Do you have concerns about your sexuality that you would like to discuss with your therapist?
 Yes No If yes, please explain. _____

CHEMICAL USE HISTORY

Please fill this chart out completely as possible by checking all substances used past and present.

Current Age _____	Age of first use	Age of last use	Method of use				Amount	How Often?	Used in last 48 hours		Used in the last 30 days	
			Oral	Injecton	Smoke	Inhale			Yes	No	Yes	No
Caffeine												
Nicotine												
Alcohol												
Barbiturates												
Valium / Librium												
Cocaine/Crack												

Heroin/Opiates												
Marijuana												
PCP												
LSD												
Mescaline												
Inhalants												
Ecstasy												
Crank/Ice												
Other												

Has anyone ever told you that alcohol and/or drug use are causing you problems? Yes No
 If so, Whom? _____

Have you ever sought help for alcohol and/or drug problems? Yes No
 If so, when? _____

What is your drug/substance of choice? _____ When did you last use? _____

How much did you use on that date? _____

Do you drink or use drugs more then you did last year? Yes No How much? _____

Has drinking or drug use ever caused problems in your life? Yes No

Have you ever taken more then the prescribed dosage of any medication? Yes No

Have you ever overdosed on drugs? Yes No

Are your drinking/drug habits different on working days then on non-working days? Yes No

Have you ever had problems with anger during drinking/drug use? Yes No

Do drugs /alcohol help you sleep? Yes No

Do you drink or use drugs while you are alone? Yes No

Have you experienced family problems due to your drinking or drug use? Yes No

Has drugs/alcohol use caused problems with your job or schooling? Yes No

Have you ever attended alcoholics or narcotics anonymous? Yes No When? _____

What is your longest period of clean / sober time? _____ When? _____

Do you know why you relapsed? Yes No If yes, please escribe _____

Have you ever been admitted to an in-patient SA facility? Yes No

If yes, when: _____ Where: _____

Have you ever experienced any of the following before, during, or after drug/alcohol use?

Hallucinations Yes No
Blackouts Yes No
Seizures Yes No
DT's Yes No

Insomnia Yes No
Sweats Yes No
Nausea Yes No
Weight loss Yes No

Would you like more information on alcohol and/or drug abuse? Yes No

NUTRITIONAL PATTERNS

Height: _____ Weight: _____ Are you on a special Diet? Yes No

What kind? _____ Why? _____

When was the last time you exercised? _____

Do you eat less than three meals per day? Yes No

Do you binge eat? Yes No

If yes, describe: _____

Has your weight changed by more than 10 pounds in the past year? Yes No Up Down

If yes, how much? _____

Do you have any concerns about your eating patterns? Yes No

If yes, explain _____

Client Signature _____ Date _____

Parent/Legal Guardian _____ Date _____

Therapist Signature/Credentials _____ Date _____

ADDITIONAL INFORMATION

Is there anything else that you feel is important for your therapist to know about? If yes, please comment in the space provided and on the back if you need more room, thank you.
