

## 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 problem?**

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**Please check if and how often you experience the following symptoms.**

Symptom	Daily	Weekly	Monthly		Symptom	Daily	Weekly	Monthly
Overall depression					Shortness of breath			
Can't concentrate					Feeling Smothered			
Tired/Exhausted					Isolating			
Keyed up or Edgy					Alcohol/drug use			
Feeling Hopeless					Sweating, clammy			
Feeling Helpless					Trembling or Shaky			
Restless					Decreased pleasure			
Irritable					Can't sleep			
Discontent					Too much sleep			
Easily angered					Overall anxious feeling			
Overeating					Always afraid			
Not eating enough					Rapid Heart Rate			

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

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**What would you like to accomplish during treatment?**

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## COUNSELING AND PRIOR TREATMENT

Please list all previous treatment experiences.

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

Have you ever experienced any suicidal thoughts? Yes  No  Current Past  
If yes, please describe; and if they are current, please provide some details.

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Have you ever attempted suicide? Yes  No   
If yes, list how many times, the most recent date, and the method (s) used.

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Have you experienced any homicidal thoughts? Yes  No  Current Past  
If yes, please describe; and if they are current, please provide some details.

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Have you ever acted on these thoughts? Yes  No   
If yes, list how many times, the most recent date, and the method (s) used.

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Have you ever assaulted anyone? Yes  No   
If yes, list how many times, and include the dates and how the assault(s) happened.

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## PHYSICAL & MEDICAL HISTORY

I have had a physical exam in the past two years. One year if over age 40.  Yes  No

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

Please list any known drug or other allergies. \_\_\_\_\_

I have had a substance abuse diagnosis in the past.  Yes  No

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 \_\_\_\_\_

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

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

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

Medication	Dosage	RX Date	Doctor	Reason

FAMILY INFORMATION						
	Name	Age	Deceased		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						
Siblings						


Please list anyone else living with you.

	Age	Relationship to you

**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
- Parents ever separated
- Parents ever divorced
- Mother remarried: Number of times \_\_\_\_\_
- Father remarried: Number of times \_\_\_\_\_
- 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?

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

Family Member	Type of Illness	When

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

Family Member or Friend	Attempted / Committed	When

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

**Have you experienced any of the following?**

Current	Past	No	Current	Past	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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. \_\_\_\_\_

**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 \_\_\_\_\_

**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 \_\_\_\_\_

**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

**EDUCATION**

**Check all that apply:**

Earned high school diploma (year) \_\_\_\_\_       Earned G.E.D. (year) \_\_\_\_\_

Did not complete high school. Last grade completed \_\_\_\_\_

Currently attending high school: grade \_\_\_\_\_.

Currently attending college or university: year \_\_\_\_\_.

Major or field of study \_\_\_\_\_.

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.

\_\_\_\_\_  
\_\_\_\_\_

**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**

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> Employed full-time   | <input type="checkbox"/> Laid off  | <input type="checkbox"/> Medical Disability |
| <input type="checkbox"/> Employed part-time   | <input type="checkbox"/> Retired   | (Type) _____                                |
| <input type="checkbox"/> Currently unemployed | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Suspended          |

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			\$

**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 \_\_\_\_\_

**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?

- |   |   |
|---|---|
| <b>Daily/ Weekly/ Monthly</b>   | <b>Daily/ Weekly/ Monthly</b>   |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Art              | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Books/Films      |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Music            | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physical Fitness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crafts           | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diet/Health      |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Outdoor activity | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sports           |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Church activity  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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 \_\_\_\_\_

**CHEMICAL USE HISTORY**

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  If yes, please describe \_\_\_\_\_

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 describe \_\_\_\_\_

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												

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 \_\_\_\_\_

**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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature/Credentials \_\_\_\_\_ Date \_\_\_\_\_