# *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? When did these issues start?**

_____

_____

**Symptom Checklist:** (check all that apply)

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

**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 counseling?**

_____

_____

## 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 | | Current | Past | No | |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | Physical Abuse | ❑ | ❑ | ❑ | Problems in school |
| ❑ | ❑ | ❑ | Sexual Abuse | ❑ | ❑ | ❑ | Trauma from crime |
| ❑ | ❑ | ❑ | Emotional Abuse | ❑ | ❑ | ❑ | Emotional difficulty due to divorce |
| ❑ | ❑ | ❑ | Neglect | ❑ | ❑ | ❑ | Sibling conflicts |
| ❑ | ❑ | ❑ | Protective Service Involvement | ❑ | ❑ | ❑ | Parenting problems |
| ❑ | ❑ | ❑ | Severe childhood illnesses | ❑ | ❑ | ❑ | 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 / Age |
|---|---|---|
| | | |
| | | |

## PHYSICAL & MEDICAL HISTORY

Last physical exam: Date: _____ Performed by: _____

Address of Personal Physician _____

_____Telephone No._____

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

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

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: _____

Do you have access to medical insurance? ❑ Yes ❑ No

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

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

Have you experienced or been treated for any of the following problems? ❑ Yes ❑ No

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

If Other, please list: _____

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

| Medication | Dosage | RX Date | Doctor | Reason |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Is there any family history of medical issues? ❑ Yes ❑ No

If Yes, please list: _____

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

If Yes, please list: _____

| 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 |
|---|---|---|
| | | |
| | | |

**Parental Information:**

- ❑ Parents legally married: how long _____
- ❑ Parents ever separated: your age _____
- ❑ Parents ever divorced: your age _____
- ❑ Mother remarried: your age _____
- ❑ Father remarried: your age _____
- ❑ I was adopted and/or placed in foster homes. your age _____

**Do you have any conflicts with family members?** ❑Yes ❑No

If Yes, Please explain: _____

**How would you describe your current relationships with family:** ❑ Good ❑ Fair ❑ Poor

Please list any other family 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 wish to have any family members or close friends involved in your treatment? Yes ❑ No ❑

If Yes, Who: _____

**Marital Status:**

❑ Single
❑ Unmarried & living with significant other
Length of time _____
❑ Married, age when married _____
Length of time _____
❑ Divorced, age when divorced _____
Length of time _____
❑ Widowed, age when 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

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

| Family Member | Type of Illness | When |
|---|---|---|
| | | |
| | | |

## 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 | | Daily | Weekly | Monthly | |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | Art | ❑ | ❑ | ❑ | Books/Films |
| ❑ | ❑ | ❑ | Music | ❑ | ❑ | ❑ | Physical Fitness |
| ❑ | ❑ | ❑ | Crafts | ❑ | ❑ | ❑ | Diet/Health |
| ❑ | ❑ | ❑ | Outdoor activity | ❑ | ❑ | ❑ | Sports |
| ❑ | ❑ | ❑ | Church activity | ❑ | ❑ | ❑ | 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

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_____

## 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_____

## SUPPORTS / STRENGHTS / SOCIAL

Who do you feel you can look to for support? _____

If you were in need of help, or needed to talk to someone, who would you turn to?

_____

Do you feel that family members support each other? Yes ❑ No ❑

If no, explain_____

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

_____

Please list your strengths: _____

_____

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

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._____

## EMPLOYMENT

**Check all that apply**

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

Are you satisfied with your current job? Yes ❑ No ❑

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

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 | | | **$** |
| | | Total Household Income | **$** |

## EDUCATION

❑ Earned high school diploma (year) _____ ❑ Earned G.E.D. (year) _____
❑ Did not complete high school. Highest grade completed _____ School: _____
❑ Currently attending college or university: year_____. Where: _____
❑ 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.

_____

_____

## 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:**

_____

## CHEMICAL USE HISTORY

Do you have a problem with Alcohol? Yes ❑ No ❑

Do you have a problem with Drugs? Yes ❑ No ❑

**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 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? _____

Have you ever experience withdrawal symptoms? Yes ❑ No ❑

Have you ever experience increased tolerance to drugs or alcohol? Yes ❑ No ❑

Have you ever used drugs or alcohol in the morning? Yes ❑ No ❑

Have you ever experience blackouts due to your drug and alcohol use? Yes ❑ No ❑

Have you ever felt that you were unable to cut down/ quit/or control you use? Yes ❑ No ❑

Have you ever experience hallucinations due to your drug and alcohol use? Yes ❑ No ❑

Have you ever substituted drugs and alcohol for other drugs? Yes ❑ No ❑

Have you ever used drugs or alcohol despite medical warnings? 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 experience financial problems due to your drug and alcohol use? Yes ❑ No ❑

Have you ever experience emotional problems due to your drug and alcohol use? Yes ❑ No ❑

Has your drug or alcohol use ever caused memory or problems concentrating? Yes ❑ No ❑

Have you ever taken a breathalyzer test? Yes ❑ No ❑ Results: _____

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:_____

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 then three meals per day? Yes ❑ No ❑

Do you binge eat? Yes ❑ No ❑

If yes, describe: _____

Has your weight changed by more then 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.