DBT PSYCHOLOGICAL SERVICES of Long Island

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Date of appointment: _____ **Time of appointment:** _____

Client Name: _____ **Age:** _____ **DOB:** _____

Gender: ☐ Male ☐ Female ☐ Transgender **Preferred Name/Nickname:** _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** _____

Current Marital/Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Name of Person completing form: _____ **Relationship to client:** _____

PRESENTING PROBLEM (Briefly describe the issues/problems which led to your decision to seek therapy services):

_____

_____

_____

How severe, on a scale of 1-10 (with 1 being the most severe), **do you rate your presenting problems?**

MOST SEVERE 1 2 3 4 5 6 7 8 9 10 LEAST SEVERE

PRESENTING PROBLEM CATEGORIZATION: (Please check all the apply and circle the description of symptom)

Symptoms causing concern, distress or impairment:

☐ **Change in sleep patterns** (*please circle*): sleeping more sleeping less difficulty falling asleep difficulty staying asleep difficulty waking up difficulty staying awake

☐ **Concentration:** Decreased concentration Increased or excessive concentration

☐ **Change in appetite:** Increased appetite Decreased appetite

☐ **Increased Anxiety** (describe): _____

☐ **Mood Swings** (describe): _____

☐ **Behavioral Problems/Changes** (describe):

_____

_____

☐ **Victimization** (*please circle*): Physical abuse Sexual abuse Elder abuse Adult molested as child

Robbery victim Assault victim Dating violence Domestic Violence

Human trafficking DUI/DWI crash Survivors of homicide victims

Other: _____

Other (Please describe other concerns): _____

_____

How long has this problem been causing you distress? (please circle)

One week One month 1 – 6 Months 6 Months – 1 Year Longer than one year

How do you rate your current level of coping on a scale of 1 – 10 (with 1 being unable to cope)**?**

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

EMPLOYMENT:

Currently Employed? ☐ Yes ☐ No **If employed**, what is your occupation? _____

Where are you working? _____

How long? _____ Days/Months/Years

Do you enjoy your current job? ☐ Yes ☐ No What do you like/dislike about your job? _____

_____

_____

If you are not currently employed, how long has it been since you last worked? _____ Months/Years

What was your occupation before becoming un-employed? _____

What led to becoming un-employed? _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Are you currently being seen by a counselor? ☐ Yes ☐ No

If yes, name of current counselor _____ Length of Treatment _____

Are you currently being seen by a psychiatrist? ☐ Yes ☐ No

If yes, name of current psychiatrist _____ Length of Treatment _____

Have you ever been diagnosed with a mental health, emotional or psychological condition?

☐ Yes ☐ No

If yes, what diagnosis were you given? _____

When? _____

By Whom? _____

Previous counseling/hospitalizations for mental health/drug and alcohol concerns

Dates of Service	Place/Provider	Reason for treatment	Were the services helpful

SAFETY CONCERNS:

Are you presently suicidal? ☐ Yes ☐ No If Yes, please explain _____

Have you ever attempted to commit suicide? ☐ Yes ☐ No If yes, when and how? _____

_____

Is there a history of suicide in your immediate and/or extended family? ☐ Yes ☐ No

Are you presently homicidal? ☐ Yes ☐ No If Yes, please explain _____

_____

Additional Information: (please add additional information as needed to address past and current safety issues)

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Please identify if any members of your family have had a history of any of the following mental health/drug abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										

RELATIONSHIP/MARITAL STATUS

Current Marital/Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Live-In Partner ☐ Significant Other (Not Living Together)

If applicable, list divorces and separations:

_____

How do you identify yourself: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Questioning

What do you think is important for us to know about your significant relationships – current & past?

_____

_____

FAMILY COMPOSITION

Spouse/Significant Other's Name: _____ **Age:** _____ ☐ **Living with client** ☐ **Not living with client**

Employed Currently: ☐ Yes ☐ No If Yes, place of employment: _____

Occupation: _____

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home. Please include all members currently residing in YOUR household.

Name	Gender	Age	Relationship To Client	Living With Client
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

What else do you feel/believe would be helpful, or important for us to know/understand about your relationships with your family or about your family members?

_____

_____

RECENT LOSSES:

☐ Family Member ☐ Friend ☐ Health ☐ Lifestyle ☐ Job ☐ Income ☐ Housing ☐ None

Who? _____ When? _____ Nature of Loss? _____

Other Losses: _____

HOUSING:

Would you consider your housing to be: ☐ **stable** ☐ **unstable**

Do you currently:

☐ Own ☐ Rent ☐ Live with relatives/friends (temporary) ☐ Emergency Shelter

☐ Live with relatives/friends (permanent) ☐ Homeless ☐ Transitional Housing

How long have you lived in your current living situation? _____

How often have you moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

_____

_____

FOSTER CARE INVOLVEMENT:

Have you ever been in foster care? ☐ Yes ☐ No From _____ age to _____ age

Reason: ☐ Familial Placement ☐ Non-Familial Placement

HEALTH HISTORY

How would you describe your overall health? _____

Do you have any health issues? ☐ Yes ☐ No If Yes, please list below.

Do you have any recurrent medical conditions such as allergies or asthma? ☐ Yes ☐ No

If yes, please list: _____

Please list below current medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.

Medical Conditions	Are you currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Do you currently take any medications? ☐ Yes ☐ No

Please list medications (including psychotropic, over-the-counter, herbal remedies) that you have taken in the past 6 months

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Are you taking the medications as prescribed? ☐ Yes ☐ No If No, please explain: _____

_____

Additional information (if needed):

_____

_____

Have you ever had a serious accident/illness or hospitalization? ☐ Yes ☐ No

Please list all past hospitalizations, surgeries, accidents, or illnesses in the chart below.

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Primary Care Doctor: _____ Facility: _____ Phone Number: _____

ALCOHOL/DRUG ASSESSMENT:

Current or past history of alcohol/drug use? ☐ Yes ☐ No If Yes, complete table below. If no history, move to next section.

Do you ever drink or use more than you intend to? ☐ Yes ☐ No If yes, how often: ☐ Almost every time

☐ Occasionally ☐ Seldom ☐ More often lately ☐ When under stress ☐ Other: _____

Have you ever had to increase the amount of alcohol/drug you consume to get the same effect?

☐ Yes ☐ No If Yes, when did you first notice this change? _____

Do you have a history of overdosing on alcohol/drugs? ☐ Yes ☐ No If yes, when was the last OD? _____

Have you ever experienced a black out? ☐ Yes ☐ No If Yes, how often: ☐ Almost every time

☐ Occasionally ☐ Seldom ☐ More often lately ☐ When under stress ☐ Other: _____

Do you have a history of seizures while under the influence? ☐ Yes ☐ No

With whom do you typically consume alcohol? ☐ Friends ☐ Family ☐ N/A-Alone ☐ Strangers ☐ Other

Have you ever experienced problems related to your alcohol use? ☐ Yes ☐ No

☐ Legal ☐ Social/Peer ☐ Work ☐ Family ☐ Friends ☐ Financial

If yes, please describe: _____

If yes, have you continued to drink/use drugs? ☐ Yes ☐ No

LEGAL INVOLVEMENT:

Please indicate by checking below your legal status.

☐ No Involvement ☐ Probation | Length: _____ ☐ Parole | Length: _____

☐ Charges Pending ☐ Prior Incarceration ☐ Law Suit or other Court Proceeding

Charges: _____ Probation/Parole Officer's Name: _____

Contact #: _____

Additional Information: _____

HISTORY OF ABUSE/NEGLECT:

Have you ever been abused or assaulted? ☐ Yes ☐ No If Yes, please complete the chart below.

Type of Abuse	By Whom?	At What Age?	Was it Reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No

Do you feel like you are in danger now? ☐ Yes ☐ No

What else do you feel is important for us to know?

_____

_____

HISTORY OF VIOLENCE:

Have you ever been accused of abusing or assaulting someone? ☐ Yes ☐ No If yes, please complete chart below.

Type of Abuse	To Whom?	At What Age?	Was it Reported?
☐ Sexual			☐ Yes ☐ No
☐ Physical			☐ Yes ☐ No
☐ Emotional			☐ Yes ☐ No
☐ Verbal			☐ Yes ☐ No
☐ Abandoned/Neglected			☐ Yes ☐ No

What else do you feel/believe is important for us to know? _____

_____

STRENGTHS/RESOURCES/SUPPORTS:

What limitations do you have (if any)?_____

What strengths do you have? _____

What resources do you have to help with your current problem?

_____

What experiences (past & present) will help you in improving the current situation?

_____

_____

What are you (and your family) already doing to improve the current situation?

_____

Who can you count on for support? ☐ Parents ☐ Boyfriend/Girlfriend ☐ Siblings ☐ Pastor
☐ Extended Family ☐ Friends ☐ Neighbors ☐ School Staff ☐ Church ☐ Therapist ☐ Group
☐ Community Services ☐ Doctor ☐ Other: _____

CURRENT NEEDS/GOALS

What do you feel is your biggest need right now? _____

What do you most hope to gain from coming to counseling? _____

If you were to pick three goals to work on, what would they be?

Goal 1: _____

Goal 2: _____

Goal 3: _____

What else would you like for us to be aware of?

_____

_____

_____

INDIVIDUAL COMPLETING ASSESSMENT

Printed Name _____ **Date:** _____

Signature _____

Relationship to client _____