Solarity Mental Health, PC 3787 River Rd Dr N, Suite A, Keizer OR 97303 phone 503-763-1778 fax 503-980-7888

Client's name: ________________________________ Date: ________________

What problem or issue are you here to address?____

CURRENT SYMPTOM/BEHAVIOR CHECKLIST (Rate intensity of signs and symptoms current and/or recently experienced)

None This symptom not present at this time; **Mild** Impacts quality of life (QOL) but no significant impairment of day-to-day functioning

Moderate Significant impact on QOL and/or day-to-day functioning; **Severe** Profound impact on QOL and/or functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed /sad	[ ]	[ ]	[ ]	[ ]	poor concentration	[ ]	[ ]	[ ]	[ ]	missing school or work	[ ]	[ ]	[ ]	[ ]
emotional/tearful	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]	somatic complaints	[ ]	[ ]	[ ]	[ ]
irritability/snappy	[ ]	[ ]	[ ]	[ ]	impulsive	[ ]	[ ]	[ ]	[ ]	disrupts family activity	[ ]	[ ]	[ ]	[ ]
feeling empty	[ ]	[ ]	[ ]	[ ]	disorganized	[ ]	[ ]	[ ]	[ ]	expelled from school	[ ]	[ ]	[ ]	[ ]
loss of interest	[ ]	[ ]	[ ]	[ ]	forgetfulness	[ ]	[ ]	[ ]	[ ]	gender dysphoria	[ ]	[ ]	[ ]	[ ]
loss of motivation	[ ]	[ ]	[ ]	[ ]	procrastination	[ ]	[ ]	[ ]	[ ]	food restricting	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	unfinished tasks	[ ]	[ ]	[ ]	[ ]	purging/vomiting	[ ]	[ ]	[ ]	[ ]
sleep problems	[ ]	[ ]	[ ]	[ ]	annoying habits	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]
tired all the time	[ ]	[ ]	[ ]	[ ]	physical tics	[ ]	[ ]	[ ]	[ ]	appetite decrease	[ ]	[ ]	[ ]	[ ]
sleeping too much	[ ]	[ ]	[ ]	[ ]	oppositional/argues	[ ]	[ ]	[ ]	[ ]	significant weight loss	[ ]	[ ]	[ ]	[ ]
feeling rejected	[ ]	[ ]	[ ]	[ ]	bullies/intimidates	[ ]	[ ]	[ ]	[ ]	overeating/bingeing	[ ]	[ ]	[ ]	[ ]
negativity	[ ]	[ ]	[ ]	[ ]	cruel to animals	[ ]	[ ]	[ ]	[ ]	significant weight gain	[ ]	[ ]	[ ]	[ ]
hopelessness	[ ]	[ ]	[ ]	[ ]	destroys property	[ ]	[ ]	[ ]	[ ]	hearing voices	[ ]	[ ]	[ ]	[ ]
overly self critical	[ ]	[ ]	[ ]	[ ]	attacks people	[ ]	[ ]	[ ]	[ ]	visual hallucinations	[ ]	[ ]	[ ]	[ ]
explosive/tantrums	[ ]	[ ]	[ ]	[ ]	dishonesty/lying	[ ]	[ ]	[ ]	[ ]	paranoid ideation	[ ]	[ ]	[ ]	[ ]
silly/elated moods	[ ]	[ ]	[ ]	[ ]	stealing/theft	[ ]	[ ]	[ ]	[ ]	odd beliefs/powers	[ ]	[ ]	[ ]	[ ]
over sexualized	[ ]	[ ]	[ ]	[ ]	obsessive thoughts	[ ]	[ ]	[ ]	[ ]	traumatic experience	[ ]	[ ]	[ ]	[ ]
poor decisions	[ ]	[ ]	[ ]	[ ]	compulsive rituals	[ ]	[ ]	[ ]	[ ]	intrusive memories	[ ]	[ ]	[ ]	[ ]
wreck less driving	[ ]	[ ]	[ ]	[ ]	gambling/gaming	[ ]	[ ]	[ ]	[ ]	nightmares	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	frequent worry	[ ]	[ ]	[ ]	[ ]	morbid thoughts	[ ]	[ ]	[ ]	[ ]
suicidal thoughts	[ ]	[ ]	[ ]	[ ]	anxiety attacks	[ ]	[ ]	[ ]	[ ]	homicidal thoughts	[ ]	[ ]	[ ]	[ ]
suicidal behavior	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	fears or phobias	[ ]	[ ]	[ ]	[ ]
self harm or cutting	[ ]	[ ]	[ ]	[ ]	leg bobbing	[ ]	[ ]	[ ]	[ ]	agitation/paces	[ ]	[ ]	[ ]	[ ]
History of suicide attempt?		Yes[ ]		No [ ]	restrictive thinking	[ ]	[ ]	[ ]	[ ]	sensory sensitive	[ ]	[ ]	[ ]	[ ]

SUBSTANCE USE HISTORY (check all that apply) **Substances used: [ ] not applicable**

Substance Abuse	First use	Last used	Substance / Frequency & Amount	Current	Consequences
alcohol				**Y / N**	
marijuana or dabs				**Y / N**	
ecstasy, cocaine, crack				**Y / N**	
amphetamines				**Y / N**	
inhalants (e.g., glue, gas)				**Y / N**	
hallucinogens (e.g., LSD)				**Y / N**	
mushrooms/psilocybin				**Y / N**	
heroin / opioids				**Y / N**	
sedatives / sleeping pills				**Y / N**	
Prescriptions				**Y / N**	
energy drinks/ caffeine				**Y / N**	
nicotine/cigarettes				**Y / N**	
Over the counter				**Y / N**	
Drug of choice?					
Substance use status:	[ ] active use/ abuse [ ] early full remission [ ] early partial remission [ ] sustained remission				

Substance abuse treatment history:

[ ] outpatient (age[s]_______________)

[ ] inpatient (age[s]_______________)

[ ] 12-step program (age[s]__________)

[ ] stopped on own (age[s]__________)

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges

[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss

[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests

[ ] overdose [ ] loss of control amount used [ ] relationship conflicts [ ] school suspension

Other describe:____

____

Family drug and alcohol Use:

Does any member in your home, consume more than 4 drinks for women or 7 drinks for men in one day? Y/ N – never sometimes often

Is the drug use of a family member affecting you (the client) ? ____

____

MEDICAL HISTORY (check all that apply for client)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor Last physical exam____________________ Height ______Weight ______

Name primary care provider: Name ___________________________Phone__________________________ Clinic name ____________________

List name of specialist: (if any): Name __________________________Phone _________________________ Clinic name ____________________

List any known allergies: ____-

____

List any medications currently being taken (give dosage time & reason): include over the counter and herbal preparations (dose /time)

____

____

____

Hospitalization, illness, accidents or injuries:

Date _______Age ____Reason _________________________________

List any abnormal lab test results

Date_________ Result ________________________________

[ ] other chronic or serious health problems ____

____

Current physical concerns

Head: [ ] headaches [ ]ears ringing [ ]congestion [ ]nose bleeds [ ]sore throat [ ]head injury [ ] no concerns

Eyes: [ ] dryness [ ] blurred vision [ ]double vision [ ] photophobia [ ] glasses [ ] contacts [ ] no concerns

Respiratory: [ ] excessive cough [ ] shortness of breath [ ] wheezing [ ] breathing difficulty [ ] no concerns

Cardiovascular: [ ] chest pain [ ] palpitations [ ] murmur [ ] family history of sudden cardiac death [ ] no concerns
[ ] numbness or tingling of extremities [ ] cold extremities/poor circulation [ ] recent fainting

Gastrointestinal: [ ] heartburn [ ] nausea [ ] diarrhea [ ] constipation [ ] other toileting issues
[ ] loss of Appetite [ ] increased appetite [ ] recent change in wt [ ] gain ______#[ ] loss______ #
[ ] gluten sensitive [ ] lactose intolerance [ ]food allergies________________ [ ] no concerns

Genitourinary: [ ] painful urination [ ] infection [ ] urgency [ ]frequency [ ] bed wetting day/night [ ] no concerns

Musculoskeletal: [ ] body aches [ ] tense or sore [ ] restless legs [ ] surgery [ ] injuries [ ] chronic pain [ ] no concerns

Skin: [ ]rash [ ] skin picking, [ ]nail biting [ ]self-harm [ ] no concerns

Neurological: [ ]dizziness [ ]sensory sensitive [ ] seizures [ ] loss of consciousness [ ] weakness [ ]tics [ ] no concerns

Endocrine: [ ] taking hormones [ ]contraceptives [ ] diabetes [ ] other concerns [ ] no concerns

Menarche (females) ____

Sleep Problem: [ ] sleep delay[ ] mid stage [ ]early [ ] fatigue [ ]nightmares [ ]sleep walking [ ] no concerns

____

____

MENTAL HEALTH TREATMENT HISTORY

Current therapist? ____

modality____

Prior <u>in</u>patient treatment/hospitalization for a psychiatric, emotional, or substance use disorder?

No Yes

When and where? (Facility name, City, State, Phone, Diagnosis, Intervention/Modality, Beneficial?)

____

____

____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent client)

Birth:. [ ] normal delivery [ ] difficult delivery [ ] cesarean delivery [ ] illness during pregnancy **birth weight** _____ lbs ________oz

Birth issues: [ ] complication [ ] premature [ ]birth defects/corrections [ ]congenital heart problems

Early term substance exposure: [ ] tobacco [ ] alcohol [ ] stimulants [ ]prescriptions [ ]lack of prenatal care

Temperament (circle all that apply to describe client as an infant/toddler)

Cuddly	Curious	Difficult to sooth	Cried a lot
Irritable / tantrum behavior	Active	Withdrawn	Easily startled
Easy to put on a schedule	Good sleeper	Friendly	Easy baby
Slow to warm up	Tense/ on edge	Afraid of strangers	Avoided eye contact

Delayed developmental milestones

[ ] normal range [ ] info not available

(check any that **did not** occur at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other ______________________________
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Earlier childhood and pre adolescent **Emotional / behavior problems** (check all that apply):

[ ] day wetting
[ ] encopresis
[ ] stealing
[ ] chronic lying
[ ] fire-setting
[ ] animal cruelty
[ ] assaults others
[ ] violent temper
[ ] destroys property
[ ] not trustworthy
[ ] extreme worrier
[ ] indecisive
[ ] very shy
[ ] immature
[ ] self-injurious threats
[ ] self-injurious acts
[ ] frequently tearful
[ ] often sad
[ ] disobedient
[ ] lack of attachment
[ ] frequently daydreams
[ ] hyperactive
[ ] impulsive
[ ] clumsy
[ ] climbs inappropriately
[ ] breaks things accidentally
[ ] poor concentration
[ ] easily distracted
[ ] bizarre behavior/rocking/flapping
[ ] fascination with spinning

FAMILY HISTORY-Biological

Describe biological parents:

Mother's name:________________________ occupation ______________ education ______________ general health ______________ Unknown

Father's name: ________________________ occupation ______________ education ______________ general health ______________ Unknown

No of # Brothers ______Sisters______ half-brothers ______half-sisters_____

[ ] [ ] Has any family member used mental health prescription medications? If yes, who/what/why (list all):________________
No Yes ____

____

____

[ ] [ ] Has any family member had outpatient psychotherapy? If yes, who/why (list all):_________________________________
No Yes ____

[ ] [ ] Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes,
No Yes who/why (list all):____

Biological family medical history:

[ ] thyroid problems [ ] diabetes [ ] high blood pressure [ ] stroke [ ] heart disease [ ] mental retardation [ ] birth defects
[ ] behavior problems [ ] emotional problems[ ] alcoholism [ ] drug abuse [ ] clinical depression [ ] bipolar disorder
[ ] Other disorder

chronic or serious illness ____

____

____

Suspected but undiagnosed illness in the biological family ___________________________________

____

FAMILY HISTORY-environmental

Marital status of parents : [ ] single, never married; [ ] engaged __ months; [ ] married for ____ years; [ ] divorced for _____ years; [ ] separated for _____ years; [ ] divorce in process____ months [ ] live-in for _ years [ ] prior marriages (self)______ [ ] prior marriages (partner)___

List all persons currently living in client's household:

Name	Age	gender	Relationship to client
		M/F	
		M/F	
		M/F	
		M/F	
		M/F	

List children/siblings not living in same household as client:______________________________________

Other family issues ____

Describe childhood family experience:
[ ] outstanding home environment [ ] normal home environment [ ] chaotic home environment
[ ] **witnessed** physical / verbal / sexual abuse toward others [ ] **experienced** physical / verbal / sexual abuse
Describe any significant issues:____
____
____
____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Current social interaction (check all that apply):
[ ] normal social interaction
[ ] isolates self
[ ] very shy
[ ] poor boundaries
[ ] inappropriate sex play
[ ] dominates others
[ ] associates with acting-out peers
[ ] other ___________________

Intellectual / academic functioning (check all that apply):
[ ] normal intelligence
[ ] high intelligence
[ ] learning problems
[ ] Dropped out or quit
[ ] authority conflicts
[ ] attention problems
[ ] underachieving
[ ] mild retardation
[ ] moderate retardation
[ ] severe retardation
Current or highest education level ______________

Living situation in our family:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional
[ ] history of foster care

Education:
[ ] public school
[ ] private school
[ ] alternative school
[ ]online school
[ ] 504 plan
[ ] IEP

Employment:
[ ] unemployed
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unstable work history
[ ] supervisor conflicts
[ ] coworker conflicts

Social support system:
[ ] supportive network
[ ] extended family support
[ ] substance-use-based friends
[ ] no friends
[ ] few friends
[ ] distant from family of origin
[ ] church support

Financial situation:
[ ] no current financial problems
[ ] impulsive spending
[ ] conflicts over finance
[ ] poverty or below-poverty

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) substance-related
[ ] arrest(s) not substance-related
[ ] court ordered this treatment
[ ] crime victim/trial pending
[ ] jail/prison ________ time(s)
total time served: ____________

Sexual history: **[ ] not applicable at child's age**
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] experiencing concerns
[ ] gender congruent
[ ] gender non congruent
[ ] history of unsafe sex age
[ ] history of promiscuity age ___

Pronoun preference (circle) he/him they them she/her

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): _______________________
____
currently participate in spiritual activities? Yes [ ] No [ ]
my family supports my spiritual activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]

What helps you make it through difficult times?________
____
____
Strengths and interest______ ______________________________
____

SOURCES OF DATA PROVIDED: [ ] Client self-report [ ] Parent report [ ] Family members [ ] other sources