Comprehensive

Psychological Health

Self-Evaluation

This evaluation is designed to help you understand your life challenges more clearly, and to help me better know how to help you. It is comprehensive in that it evaluates many domains of your life, and because of that, it may take you up to an hour (sometimes longer) to complete. There is *no need to do it all in one sitting*, so feel free to take breaks if you want.

When you see "instructions" please take the time to read them, and most important, pay attention to the *time frame* specific to the questions being asked (e.g., last 7 days, last two weeks, last 6 months).

And please answer all questions as accurately and honestly as possible. If you have a problem with a question, feel free to skip it and bring it up with me in session. Remember, all your answers are confidential and covered by our confidentiality agreement.

Thanks for taking the time to do this.

Name: _____

Date of Birth: _____ Age: _____

Date: _____

Presenting Concerns & Interests

Why are you seeking psychological help? _____

_____

_____

_____

Personal Strengths

Describe important strengths that have aided you in your life thus far _____

_____

_____

_____

_____

Education

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

University / College / Trade School / Other:_____ **(circle all that apply)**

Degree(s)_____ **What field(s)?**_____

Currently enrolled in school? Yes ❑ No ❑ if yes, where?_____

How do you learn best?

- ❑ **Visual – learn through reading, seeing things, graphics, illustrations**
- ❑ **Auditory – learn by hearing information, listening to tapes, music**
- ❑ **Tactile – learn by touching things, feeling in the body, movement**

Spiritual

My family's spiritual/religious preference during my childhood was / is: _____

My current spiritual/religious preference is: _____

My current spiritual/religious practices include (meditation, prayer, church, etc.): _____

_____

Do you believe spiritual/religious issues relate to your current problems? Yes ❑ No ❑ if yes, explain:_____

_____

Employment/Financial Situation

Employed? Yes ❑ No ❑ if yes, where? _____

How long?_____ **Job title or duties:**_____

If not employed, please explain (include being disabled):_____

_____

Have you had trouble keeping jobs? Yes ❑ No ❑ if yes, why do you think so?_____

_____

Trouble with current job (circle all that apply): absenteeism / tardiness / boredom / decrease in performance

arguments with other employees / not challenged / burned-out / stress / sexual harassment / other:_____

Has your income changed a lot during the past two years? Yes ❑ No ❑ How? Gone up / Gone down

Do you have any financial difficulties? Yes ❑ No ❑ if yes, please explain:_____

_____

Legal

Have you ever been arrested? Yes ❑ No ❑ if yes, how many times?_____ if no, go to next section

Number of arrests in the last two years?_____ Charges:_____

Total number of DUI's:_____ Total DUI's in the last 5 years:_____ Date of last one:_____

How many days/months have you spent in jail or prison in your lifetime:_____

What have you been arrested for (circle all that apply): alcohol & drug offenses / crimes against people domestic violence / sex crimes / restraining order / crimes against property (burglary/theft) / Other (list):

_____

Are you currently involved in the legal system? Yes ❑ No ❑ if yes, what is your status?_____

_____

Sexual

My sexual orientation/gender is: Male ❑ Female ❑

How do you label yourself (circle): Heterosexual / Bisexual / Homosexual / Asexual / Don't know

Are you presently in a one-person relationship? Yes ❑ No ❑ if yes, how long?_____

Sexually active? Yes ❑ No ❑ Never ❑

If yes, how many partners in the past six months (circle): 1 2 3 4 5 +

Any current problems with sex that should be addressed in treatment?_____

_____

Military

Military Service? Yes ❑ No ❑ if yes, are you currently serving? Yes ❑ No ❑

Branch:_____ Discharged: Honorable / General / Medical / Dishonorable (circle one)

Dates served:_____ I had problems in the military related to addiction: Yes ❑ No ❑

I have participated in combat zone military actions: Yes ❑ No ❑ if yes, please describe:_____

_____

Physical/Medical Health

I would rate my overall physical health as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

Date of last visit with Primary Care Physician_____ Do you see any other doctors? Yes ❑ No ❑
if yes, who and for what? _____

_____

List current medical conditions you are being monitored or treated for, and indicate if care appears effective

Current conditions	Effectiveness of current care

How many times, when, and for what have you been hospitalized for medical problems in the last 5 years?

_____

_____

_____

_____

Do you exercise? Yes ❑ No ❑ if yes, how many days per week: 1 2 3 4 5 6 7

What do you do?_____

Have you ever injected any substance into your body? Yes ❑ No ❑ if yes, what?_____

Do you own any guns? Yes ❑ No ❑ if yes, are they secured from children? Yes ❑ No ❑

Mental Health

Instructions: Over the last TWO WEEKS, how often have you been bothered by any of the following problems. Circle the number that best describes the frequency of the problem.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have notice? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total Score =				

Instructions: ***Prior to your 18th birthday***, did any of the following things happen to you? Check yes or no.

	Yes	No
1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?		
4. Did you often or very often feel that… No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you often or very often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were your parents ever separated or divorced?		
7. Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, get kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes, or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? Or that had a behavioral addiction that you knew of like gambling or acting out sexually?		
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?		
10. Did a household member go to prison?		
Total Score =		

Instructions: Over the last TWO WEEKS, how often have you been bothered by any of the following problems. Circle the number that best describes the frequency of the problem.

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
2. Not being able to stop or control worrying	**0**	**1**	**2**	**3**
3. Worrying too much about different things	**0**	**1**	**2**	**3**
4. Trouble relaxing	**0**	**1**	**2**	**3**
5. Being so restless that it's hard to sit still	**0**	**1**	**2**	**3**
6. Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
7. Feeling afraid as if something awful might happen	**0**	**1**	**2**	**3**
Total Score =				

Have you ever been hospitalized for a mental health or psychological problem? Yes ❑ No ❑

If yes, how many times?_____ Why were you hospitalized? _____

_____

_____

_____

Have you ever used psychiatric medications to address a mental health problem? Yes ❑ No ❑

If yes, are you regularly taking a psychiatric medication(s) right now? Yes ❑ No ❑

If yes, what psychiatric medications are you taking right now:

Medication	Reason for Taking

<u>Instructions</u>: Looking back on your life, please rate the degree to which at any time you experienced the following phenomena. Answer each question according to your feelings, thoughts, and experiences at the time of you experienced the phenomena. In making each of your ratings, use the following scale:

0 – none; not at all
1 – so slight cannot decide
2 – slight
3 – moderate
4 – strong (equivalent in degree to any other strong experience)
5 – extreme (more than any other time in my life and stronger than 4)

_____ 1. Loss of your usual sense of time.

_____ 2. Experience of amazement.

_____ 3. Sense that the experience cannot be described adequately in words.

_____ 4. Gain of insightful knowledge experienced at an intuitive level.

_____ 5. Feeling that you experienced eternity or infinity.

_____ 6. Experience of oneness or unity with objects and/or persons perceived in your surroundings.

_____ 7. Loss of your usual sense of space.

_____ 8. Feelings of tenderness and gentleness.

_____ 9. Certainty of encounter with ultimate reality (in the sense of being able to "know" and "see" what is really real at some point during your experience.

_____ 10. Feeling that you could not do justice to your experience by describing it in words.

_____ 11. Loss of usual awareness of where you were.

_____ 12. Feelings of peace and tranquility.

_____ 13. Sense of being "outside of" time, beyond past and future.

_____ 14. Freedom from the limitations of your personal self and feeling a unity or bond with what was felt to be greater than your personal self.

_____ 15. Sense of being at a spiritual height.

_____ 16. Experience of pure being and pure awareness (beyond the world of sense impressions).

_____ 17. Experience of ecstasy.

_____ 18. Experience of the insight that "all is One".

_____ 19. Being in a realm with no space boundaries.

_____ 20. Experience of oneness in relation to an "inner world" within.

_____ 21. Sense of reverence.

_____ 22. Experience of timelessness.

_____ 23. You are convinced now, as you look back on your experience, that in it you encountered ultimate reality (i.e., that you "knew" and "saw" what was really real).

_____ 24. Feeling that you experienced something profoundly sacred and holy.

_____ 25. Awareness of the life or living presence in all things.

_____ 26. Experience of the fusion of your personal self into a larger whole.

_____ 27. Sense of awe or awesomeness.

_____ 28. Experience of unity with ultimate reality.

_____ 29. Feeling that it would be difficult to communicate your own experience to others who have not had similar experiences.

_____ 30. Feelings of joy.

Total Score: _____

Instructions: For the following questions, please consider your early childhood life (age 5 to 15). For each parent, or the two most involved caregivers in your life, please rate on a scale from 1 (least) to 7 (most) how well each of them did on the following Parenting Factors. Note that higher scores mean your parent (or caregiver) was *consistent and reliable* on each of the factors.

Parenting Factors	Mother or Caregiver #1	Father or Caregiver #2
(1) Felt Safety/Protection **Kept me safe from danger and threats**	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(2) Feeling Seen and Known (Attunement) **Was emotionally in tune with how I was feeling, could read my emotions and respond in a way that made me feel they understood how I felt**	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(3) Felt Comfort/Soothing and Reassurance **Calmed and soothed me effectively when I became upset or overwhelmed**	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(4) Feeling Valued/Expressed Delight **Made me feel special, took interest in me, made me feel valued, I was twinkle in their eye**	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(5) Felt Support for Best Self/Self-Development **Helped me express my natural talents, supported me becoming the best version of myself possible, encouraged self-exploration**	1 2 3 4 5 6 7	1 2 3 4 5 6 7

Instructions: **Listed below are a number of difficult or stressful things that sometimes happen to people. For each type of event listed, please check yes if the event: 1) happened to you personally, 2) you witnessed it, or 3) if you are not sure if it fits, but it might. Please consider your entire life as you go through the list. Then, on a scale from 1 (least impact) to 7 (greatest impact), circle the number that best represents the degree to which you feel the type of event has impacted your entire life.**

Type of Event	Yes	1= least impact						7= highest impact
1. Sexual Abuse or Assault: Actual or attempted sexual contact, exposure to age-inappropriate material, sexual exploitation, unwanted/coercive sexual acts	❑	1	2	3	4	5	6	7
2. Physical Abuse or Assault: Actual or attempted infliction of physical pain with or without an object or weapon, use of severe corporeal punishment	❑	1	2	3	4	5	6	7
3. Emotional Abuse/Psychological Maltreatment: Includes verbal abuse, emotional abuse, excessive demands on child's performance, intentional social deprivation	❑	1	2	3	4	5	6	7
4. Neglect: Failure by parents/caregivers to provide needed, age-appropriate care although financially able to do so, includes: physical, medical, educational neglect	❑	1	2	3	4	5	6	7
5. Serious Accident or Illness/Medical Trauma: Unintentional injury or accident, having a physical illness or medical procedures that are painful and/or life threatening	❑	1	2	3	4	5	6	7
6. Witnessing/Experiencing Domestic Violence: Actual or threatened physical or sexual violence, or emotional abuse between adults in intimate relationships – current or former	❑	1	2	3	4	5	6	7
7. Victim/Witness to Community Violence: Violence from people *not in your family*, brutal acts like shootings, stabbings, being robbed, raped or beaten	❑	1	2	3	4	5	6	7
8. School Violence: Includes fatal and nonfatal student or teacher victimization, threats to or injury of students, fights, or exposure to weapon on school grounds	❑	1	2	3	4	5	6	7
9. Natural or Manmade Disasters: Major accident or disaster that is an unintentional result of a manmade or natural event: hurricane, earthquake, flood, fire	❑	1	2	3	4	5	6	7
10. Forced Displacement: Forced relocation to a new home due to political reasons, including political asylees or immigrants fleeing political persecution	❑	1	2	3	4	5	6	7
11. War/Terrorism/Political Violence: Exposure to war, terrorism, political violence, includes incidents like bombing, shooting, looting, or accidents due to terrorist activity	❑	1	2	3	4	5	6	7
12. Victim/Witness to Extreme Personal/Interpersonal Violence: Includes extreme violence by or between individuals including exposure to homicide, suicide and/or other extreme events	❑	1	2	3	4	5	6	7
13. Traumatic Grief/Separation: Death of parent, primary caretaker, sibling, abrupt and/or unexpected, accidental or premature death or homicide of a close friend, family member or relative, indefinite separation from loved one	❑	1	2	3	4	5	6	7
14. System-Induced Trauma: Traumatic removal from the home, traumatic foster placement, sibling separation, or multiple placements in a short amount of time	❑	1	2	3	4	5	6	7

Substance Use

List all substances used in the last year (alcohol, cannabis, psilocybin, Ectasy, tobacco, etc.)	Average days per month you use substance
1.	
2.	
3.	
4.	
5.	
6.	

Treatment History

Have you ever seen a psychologist, psychiatrist, counselor, social worker, or other mental health professional for any mental health or addiction problems any time in the past? Yes ❑ No ❑
How many professional clinicians have you seen (estimate if needed)? _____
If yes, please list details:

Type of clinician you saw	Year started	How Long	For problems related to:
Example: psychologist	*2006*	*1.5 years*	*depression*

Are you CURRENTLY seeing any clinicians for mental health or addiction problems? Yes ❑ No ❑
If yes, who are you seeing? _____ How long? _____

Have you ever been to a TREATMENT PROGRAM (e.g. residential, intensive outpatient, outpatient) for any mental health or addiction problems any time in the past? Yes ❑ No ❑ if no, go to next section
How many independent (different) times did you attend a treatment program? _____
If yes, please list details of last five episodes:

Name of treatment program	Year started	How Long	For problems related to:	Did you complete
Kaiser Alcohol & Drug	*2009*	*3 months*	*DUII – alcohol problems*	*Yes*

Do you – or have you ever - participated in any self-help groups (e.g., 12-step, SMART, grief) for <u>mental health or addiction</u> problems? Yes ❑ No ❑ if no, go to next section

If yes, what programs?_____

_____

_____

_____

How helpful have they been?_____

_____

Family - Current

I am: single / married / separated / divorced / widowed / in a committed relationship (please circle one)

How long?_____ **If married, married to 1st / 2nd / 3rd / 4th spouse (please circle one)**

Is your spouse/partner employed? : Yes ❑ No ❑ How would you currently summarize your relationship with your spouse? very satisfied / satisfied / not sure / somewhat dissatisfied / dissatisfied

Names of biological children	Age	Any problems or issues? (substance abuse, mental health)
Names of step-children	**Age**	**Any problems or issues?**

Social – Living Environment

I currently live in: house / apartment / trailer / rent room / mission / car / street / Other_____

How long?_____**(years/months) With whom do you live?**_____

_____

Are you satisfied with current living situation: Yes ❑ No ❑ if no, explain:_____

_____

Number of times I have moved in the last five years:_____ Were moves related to current problems:_____

Number of close friends I have:_____ Number of friends I see in person at least once per week:_____

For support, who do you turn to (circle all that apply): spouse or significant other / family / friends / self-help groups / church / employer / spirituality or religion / Other:_____

What do you do for fun?_____

_____

_____

_____

END OF EVALUATION

Thank you!