SAP Personal History/Psychosocial Evaluation Form—Adult

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Please complete all items on this form and return to Dr. Garlock.

Thank You!

Client's name: __________________________ Date: _____________

Gender: ___ F ___ M Date of birth: _________________ Age: __________

Form completed by (if someone other than client): ____________________________________

Address: _______________________ City: ______________ State: _____ Zip: _________

Phone (home): ___________________ (work): _________________ ext: __________

Who referred you for our services today? Please list their name, address and phone #

____

____

____

If more space is needed for any of your answers, please use the space on the last page of this form.

Primary reason(s) for seeking services: (Check all that are applicable in your situation)

__ Positive alcohol/drug test at work (specify): ____

__ Self referral due to your having an alcohol and/or drug problem you want help with

__ Supervisor or boss told you to get this evaluation completed without a positive alcohol or drug test having been performed

__ Other reason(s). Please explain:____

Your Present Need And Expectations For Services

Please list in your own words why you are seeking Dr. Garlock's services today?

____

____

____

____

Did you have a positive Urine/Drug/Screen or Breathalyzer Test at work? ___Yes _______No If so, please list the date of the test, type of test, test outcome and the reasons for your positive alcohol and/or drug test at work:

____

____

____

____

____

____

Did you have an accident at work that led to your being tested for alcohol and/or drugs?

_________________Yes _________________No If the answer is Yes, please explain what happened at work:

____
____
____

Are you willing to attend either recommended services in order to complete the DOT requirements for you to return to work? _________Yes ___________No If not, explain below:

____
____
____

What outcome would you like to happen today with regard to your alcohol/drug related work problems due to your positive test or self referral?

____
____
____

If a miracle happened and the concerns or problems that you are seeking assistance for were resolved, what positive differences in behavior or situation or personal experiences would you expect to see occurring?

____
____
____
____

How will you know if the services that are recommended for you are successful?

____
____
____
____

Do you want to get sober and stay sober? __________Yes ___________No If not, why?

____
____
____

Are you willing to follow all of the recommendations given to you by Dr. Garlock and your recommended service provider? ___________Yes __________ No If no, why not?

____
____

Family History Information/Evaluation

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	____________________	________	____	____	____	____
Father	____________________	________	____	____	____	____
Spouse	____________________	________	____	____	____	____
Children	____________________	________	____	____	____	____
	____________________	________	____	____	____	____
	____________________	________	____	____	____	____

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
__________	____________________	________	____	____	____	____
__________	____________________	________	____	____	____	____
__________	____________________	________	____	____	____	____
__________	____________________	________	____	____	____	____

Marital Status (more than one answer may apply)

__ Single____ Divorce in process_ Unmarried, living together Length of time:___

__ Legally married ___ Separated ___ Divorced

Length of time: ___________ Length of time: __________ Length of time: ________

__ Widowed ___ Annulment

Length of time: ___________ Total number of marriages: ________________________

Assessment of current relationship (if applicable): ________ Good ____Fair ____ Poor

Parental History Information/Evaluation

__ Parents legally married___Mother remarried: Number of times: _______

__ Parents have even been separated__ Father remarried:____Number of times: ___________

__ Parents ever divorced ______ Parent(s) deceased

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

How many moves did you make with your family as a child? _____________ Did moving create problems for you as a child or adolescent? ____ Yes ____ No Did parental illness create problems for you as a child? ______ Yes _______ No Did parental substance abuse create problems for you as a child or as an adolescent? ____Yes ____No

Personal Developmental History Information/Evaluation

Are there special, unusual, or traumatic circumstances that affected your development? __ Yes ________ No

If Yes, please describe: ____

Has there been history of child abuse?______ Yes ____ No Child Neglect? ___Yes ______No

If Yes, which type(s)? _________ Sexual ___ Physical ____Verbal ______Emotional

If Yes, the abuse was as a: __________ Victim __________________________Perpetrator

Other childhood issues: _________ Neglect __ Inadequate nutrition___ Other (please specify): ____

Comments re: childhood development:

____

____

____

Social Relationships History/Evaluation

Check how you generally get along with other people: (check all that apply)

__ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

__ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn____ Submissive

__ Other (specify): ____

Sexual orientation: _______________ Comments: ____________________________________

Sexual dysfunctions? _______ Yes ____ No

If Yes, describe: ____

Any current or history of being as sexual perpetrator? ___ Yes ______ No

If Yes, describe: ____

Cultural/Ethnic Issues Evaluation

To which cultural or ethnic group, if any, do you belong? __________________________________

Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ____ No

If Yes, describe: ____

Other cultural/ethnic information: ____

____

Spiritual/Religious Evaluation

How important to you are spiritual matters? _______ Not _____ Little___ Moderate_____ Much

Are you affiliated with a spiritual or religious group? ______ Yes _______________________ No

If Yes, describe: ____

Were you raised within a spiritual or religious group? _______ Yes ______ No

If Yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? ______ Yes _ No

If Yes, describe: ____

Legal Evaluation

Current Status

Are you involved in any active cases (traffic, civil, criminal)? _______ Yes ______No

If Yes, please describe and indicate the court and hearing/trial dates and charges: __________

Are you presently on probation or parole? ______ Yes ________________________________ No

If Yes, please describe: ____

Past History

Traffic violations: ____ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement:____ Yes ____No Civil involvement:___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Educational Evaluation

Fill in all that apply: Years of education: ____ Currently enrolled in school? _______ Yes _ No

__ High school grad/GED __________List grade you stopped attending school in:___________

__ Vocational: Number of years: __ Graduated: __ Yes ____ No___Major: ______________

__ College: Number of years: __ Graduated: __ Yes __ No Major: ___________________

__ Graduate: Number of years: __ Graduated: __ Yes __ No Major: ___________________

Other training: ____Special circumstances (e.g., learning disabilities, AD/HD, gifted):____

Employment Evaluation

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____ FT ___ PT ___ Temp ___ Laid-off ___ Disabled __ Retired

__ Social Security __ Student Other (describe): ____________________________________

How many hours do you work a week? ______20 _______30 ________40 ________50 _______50+

Has anyone told you that they think that you work too much? ______Yes ______ No If yes, who told you that you work too much? ____

Are you a workaholic? _________Yes _______No If yes, why do you think so?

____

Military Evaluation

Military experience? __ Yes ___ No Combat experience? ______ Yes ___ No

Where: ____

Branch: ______________________________ Discharge date: _________________________

Date drafted: __________________________ Type of discharge: ______________________

Date enlisted: _________________________ Rank at discharge: ______________________

Leisure/Recreational Evaluation

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Do you visit the internet? ______Yes ________ No If yes, how much time do you spend on the internet daily and during an average week? __________Daily time ________Weekly time Do you think that you may have an internet overuse problem?_____Yes ____No Has anyone told you that they think that you may have an internet use/abuse problem? _______Yes _______No If yes, do you believe them or not? ____Yes ____ No If yes, please explain:____

____

Medical/Physical Health Evaluation

Please check the symptoms that you are presently having or being treated for:

__ AIDS
__ Alcoholism
__ Abdominal pain
__ Abortion
__ Allergies
__ Anemia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bronchitis
__ Bed wetting
__ Cancer
__ Chest pain
__ Chronic pain
__ Colds/Coughs
__ Constipation
__ Chicken Pox
__ Dental problems
__ Diabetes
__ Diarrhea
____ Dizziness
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Menstrual pain
____ Miscarriages
____ Neurological disorders
____ Nausea
____ Nose bleeds
____ Pneumonia
____ Rheumatic Fever
____ Sexually related diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet Fever
____ Sinusitis
____ Small Pox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems
____ Vomiting
____ Whooping cough
____ Other (describe): _______
____

List any current health concerns: ____

List any recent health or physical changes: _______________________________________

Nutritional Evaluation

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	____________________	____ No ___ Low ___ Med ___ High
Lunch	____ / week	____________________	____ No ___ Low ___ Med ___ High
Dinner	____ / week	____________________	____ No ___ Low ___ Med ___ High
Snacks	____ / week	____________________	____ No ___ Low ___ Med ___ High

Comments: ____

Current Medications Taken

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? _______ Yes____ No Do you abuse prescription drugs? ______ Yes ________ No What do you abuse?______________________________

If Yes, describe: ____

Medical Information/History/Evaluation

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _

Please check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level
__ Physical activity level ___ General disposition ___ Weight
__ Nervousness/tension ____ Moods ___ Vision/Hearing

Describe changes in areas in which you checked above: ________________________________

____

Tobacco And Caeffine Use History/Evaluation

Do you use tobacco? ________Yes _______ No If yes, how much do you use daily?_____________
How many cigarettes and cigars do you smoke a week? ____________________________________
How long have you been smoking? ____________ Years ____________ Months
What brand do you smoke?____
Do you have any health problems related or due to smoking? ________Yes _________No
Are you being treated for illnesses related to your tobacco use? _______Yes _______No What are You being treated for?____
Have you tried to quit smoking? ______Yes _______No When did you try to quit smoking? ________

Do you use caeffine?_____Yes _____No If yes, what do you use?______________________________
How many soft drinks do you drink a day? ____
How many cups of coffee or tea do you drink daily?____

Chemical Use History/Evaluation

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								

Substance(s) of preference that you like to use now

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

Substance Abuse Questions/Evaluation

Describe when and where you typically use substances: ___________________________________

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected your family or friends (include their perceptions of your use

____

Reason(s) for use:

__ Addicted ___ Build confidence ___ Escape ___ Self-medication

__ Socialization ___ Taste ___ Other (specify): __________________

How do you believe your substance use affects your life? __________________________________

Who or what has helped you in stopping or limiting your use? ___________________________

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

__ Yes __ No If Yes, describe: ____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes _ No

If Yes, describe: ____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_______________

____

Does your body temperature change when you drink? ___ Yes ____________________ No

If Yes, describe: ____

Have drugs or alcohol created a problem for your job? ______ Yes __ No

If Yes, describe: ____

Do you think you have an alcohol or drug use/abuse problem?_________Yes __________No If yes, please describe the problem:____

____

Counseling/Prior Treatment History/Evaluation

Information about client's treatment history (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	____________	____________________	______________
Suicidal thoughts/attempts	____	_____	_____________________________		________________
Drug/alcohol treatment	____	____	____________	__________________	________________
Hospitalizations	____	____	____________	__________________	________________
Involvement with self-help groups (e.g., AA, Al-Anon,	____	__	____________	_________________	_________________

Information about family/significant others (past and present):

	Yes	No	When	Who	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	____________	____________________	______________
Suicidal thoughts/attempts	____	__	____________	____________________	____________
Drug/alcohol treatment	____	____	____________	___________________	_________________
Hospitalizations	____	____	____________	___________________	_________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	_____	____________	___________________	_________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

__ Aggression
__ Alcohol dependence
__ Anger
__ Antisocial behavior
__ Anxiety
__ Avoiding people
__ Chest pain
__ Cyber addiction
__ Depression
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug dependence
__ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): ________
____

Briefly discuss how these symptoms impair your ability to function effectively:

____
____
____
____
____
____

What meaning do your symptoms have for you in terms of your daily living and need meeting?

____
____

Any additional information that would assist us in understanding your concerns or problems: __

____
____
____
____

What are your goals for services? ____

How will you know if your goals for service delivery have been met?

Do you feel suicidal at this time? ______________________________

No______________________________

Yes ______________________________

Other Information That You Would Like Dr. Garlock To Know About You:

Psychosocial Signature Section

By signing this form, I certify and attest that I have been honest in my responses and that all information contained in this interview questionnaire is accurate and honest. I certify and attest that I have not withheld any information regarding my substance use history, my legal involvement history, my work history or any other factor that could influence the outcome of this evaluation process.

Client's signature ______________________________ Date: ____/____/_____

Psychosocial Evaluator______________________________ Date: ___/____/______

Psychosocial Evaluation Rating Of Validity Of Psychosocial History Information

__________Valid ______________Partially Valid _____________Not Valid If not valid, why not?