

# Confidential Self-Evaluation

## Barth Clinic of Yakima & Kittitas Valleys

P.O. Box 1207  
Yakima, WA 98907  
Toll free (877) 457-5657

www.barthclinic.com

**PLEASE PRINT**

Date of Evaluation \_\_\_\_\_ Patient ID Number \_\_\_\_\_

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
First Last Nickname

Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Street • P.O. Box Apartment

Cell/Pager ( ) \_\_\_\_\_

City State Zip Code Date of Birth \_\_\_\_\_  
Month • Day • Year

Drivers License # \_\_\_\_\_ State \_\_\_\_\_ Age \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender M F

Ever been a patient here before? Yes No If Yes, When? \_\_\_\_\_

How did you learn about us?  
(Check the one that influenced your decision the most)

Attorney/Court/Probation  
Chemical Dependency Agency/Detox  
Physician or Hospital  
Insurance Company/Managed Care  
Employer/EAP/Union

School  
Mental Health Counselor  
Native American Tribe  
Other

Yellow Pages  
Family Member  
Friend  
Former Patient/Alumni  
Re-Admit/Relapse

If you checked a box in the above columns please write the name \_\_\_\_\_

Why are you seeking an evaluation at this time?

Please explain your version of the events leading to your referral for an evaluation.

Check the one that is closest to your race/ethnicity:

- |                         |                              |
|-------------------------|------------------------------|
| White/European American | Japanese                     |
| Black/African American  | Samoan                       |
| Native American •       | Asian India                  |
| Eskimo/Alaskan Native•  | Guamanian                    |
| Canadian                |                              |
| Aleut •                 | Cambodian                    |
| Chinese                 | Laotian                      |
| Filipino                | Thai                         |
| Hawaiian                | Other Asian/Pacific Islander |
| Korean                  | Other race                   |
| Vietnamese              | Refused to answer            |

•If Native American/Eskimo/Alaska Native/Aleut, please provide tribal information:

Tribe or corporation \_\_\_\_\_

Tribal recognition      Federal      Non-Federal

Eligible for enrollment?      Yes      No

Enrollment Number \_\_\_\_\_

Blood degree      Less than ¼      ¼ or more

Check the one that is closest to your Spanish/Hispanic origin:

- |                      |         |                        |              |       |                   |
|----------------------|---------|------------------------|--------------|-------|-------------------|
| Not Spanish/Hispanic | Mexican | Other Spanish/Hispanic | Puerto Rican | Cuban | Refused to answer |
|----------------------|---------|------------------------|--------------|-------|-------------------|

◆ **FAMILY**

Marital Status

Single (Never Married)	Since	Number of Times
Married	_____	_____
Separated	_____	_____
Divorced	_____	_____
Widowed	_____	_____
Significant other	_____	_____
Partner	_____	_____

Who are you currently living with? \_\_\_\_\_

Name & Relationship

Does the person you are now living with:		
Drink or use Drugs?	Yes	No
Drink or use Drugs to Excess?	Yes	No
Drink or use Drugs in the Residence?	Yes	No

Is there domestic violence where you live?      Yes      No

Is there any kind of physical, verbal or sexual abuse where you live?      Yes      No

Are you at risk of being abused?      Yes      No

Do you feel that you are living in a safe place?      Yes      No

Typical Daily Activities \_\_\_\_\_

Describe your childhood religious or spiritual upbringing, traditions experiences \_\_\_\_\_

Describe the religious or spiritual practices and beliefs you have now \_\_\_\_\_

Number of Brothers _____	Your Birth Order? _____	<b>Children:</b>		
Number of Sisters _____	1 <sup>st</sup> , 2 <sup>nd</sup> , etc.	Gender	Age	Name
		_____	_____	_____
Birth place _____		_____	_____	_____
Place raised _____	Who raised you? _____	_____	_____	_____
When did you leave Home & Why _____		_____	_____	_____

◆ **EDUCATION**

Years of Education \_\_\_\_\_ (1 2 3 4 5 6 7 8 9 10 11 12 etc.)

Degree:    None    GED    HS Diploma    Trade School    Associate    BA/BS    Masters    Doctorate

Did alcohol/drug use impact your educational goals?    Yes    No  
 How do you rate your English reading/writing skills?    Good    Fair    Poor  
 Have you ever been diagnosed as having a learning disability or placed in a special education class?    Yes    No

◆ **VETERAN STATUS**

Military Service?    Yes    No    Branch \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_ Highest Rank \_\_\_\_\_

Honorable Discharge?    Drink/Use In Service    Yes    No    Demotions:    Yes    No

Combat Service?    Combat Location \_\_\_\_\_

PTSD Diagnosed?    If YES, where and when diagnosed \_\_\_\_\_

Prior PTSD treatment?    If Yes, where and when treated \_\_\_\_\_

◆ **EMPLOYMENT**

Employed Full-Time    Employer \_\_\_\_\_ Location \_\_\_\_\_  
 Employed Part-Time    Length in Current Employment \_\_\_\_\_  
 Self-Employed    Position & Type of Work \_\_\_\_\_  
 Military    Number of Employers \_\_\_\_\_ Longest Time  
 Student    In Past Five Years \_\_\_\_\_ With One Employer \_\_\_\_\_  
 Homemaker    If Unemployed, What is  
 Retired    Your Source of Income \_\_\_\_\_  
 Disabled    Public Assistance  
 Unemployed (Seeking Work)  
 Unemployed (Not Seeking Work)    Do you Enjoy Your Job?    Yes    No

Have you experienced any of the following employment problems due to substance use?  
 Late for work    Less productive at work    Missed work    Quit a job  
 Used at work    Fired    Loss of license/certification    None

Is your job currently in danger?    Yes    No

◆ **FINANCIAL**

Financial Status    Good    Fair    Poor  
 Insurance    Insurance Company Name \_\_\_\_\_  
 Private Pay    Phone \_\_\_\_\_  
 Medicare    Group Number \_\_\_\_\_  
 CHAMPUS    Title XIX  
 Agency Funded    Subscriber Number \_\_\_\_\_  
 Other    Subscriber Name \_\_\_\_\_

Do you have significant financial stress at this time?    Yes    No  
 Do you have a history of gambling problems?    Yes    No

**◆LEGAL**

**Current** Legal Problem \_\_\_\_\_ Date of Offense \_\_\_\_\_ BAC or Breath Test \_\_\_\_\_

Court \_\_\_\_\_ Judge \_\_\_\_\_ Case # \_\_\_\_\_

Next Court Date \_\_\_\_\_ Case Status \_\_\_\_\_

Attorney Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Probation Officer \_\_\_\_\_ Phone# \_\_\_\_\_

Do you have your Driving Record available today?      Yes      No      Requested      Not Applicable

Do you have your Criminal Record available today?      Yes      No      Requested      Not Applicable

Do you have your Police Report available today?      Yes      No      Requested      Not Applicable

Do you have current involvement with the Department of Corrections (DOC)?      Yes      No

Outstanding Warrants?      Yes      No      What & When \_\_\_\_\_

**Past Arrests or Convictions**

Charge	Date	Court	Final Outcome	BAC
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**◆ MEDICAL & MENTAL HEALTH      (Write "None" for any questions that do not apply)**

How is your overall health now?      Excellent      Good      Fair      Poor

Current eating pattern; how many meals and snacks per day? \_\_\_\_\_

What physical or mental problems do you now have? \_\_\_\_\_

Are you currently under a doctor's care?      Yes      No      If Yes Why? \_\_\_\_\_

What is the name and address of your primary care physician? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

What prescription medications are you now taking? (name and dose) \_\_\_\_\_

What over-the-counter products (aspirin, cough medicine, etc.) are you now using? \_\_\_\_\_

Do you take any prescribed medications (Xanax, Trazadone, Celexa, Paxil, Wellbutrin, Hydrocodone etc.) and then drink alcohol?  
Yes                  No

Have you ever been seen by a mental health worker? \_\_\_\_\_ If so, why? \_\_\_\_\_

Have you or anyone in your family ever experienced any of the following problems?

(Check NONE for questions that do not apply)

You    Family   None

- Alcoholism
- Anemia
- Asthma
- Cirrhosis
- Depression
- Diabetes
- Drug Addiction
- Delirium Tremens
- Fainting
- Fatty Liver
- Gastro esophageal Reflux
- Head Injury
- Headache or Migraine
- Heart Problems
- Heartburn or gastritis
- Hepatitis
- High Blood Pressure
- ADD/ADHD
- Eating Disorder

You    Family   None

- Loss of Appetite
- Mental Illness
- Morning nausea, vomiting
- Night Sweats
- Numbness in Fingers or Toes
- Pancreatitis
- Anxiety or Nervousness
- Recurrent diarrhea
- Seizures
- Shaking
- Significant weight loss or gain
- Sleep problems
- Suicide attempts or plans
- TB
- Ulcers
- Physical, sexual or emotional abuse
- Obsessive, compulsive behaviors
- Other:

How many times in the past five years have you been hospitalized? \_\_\_\_\_ When? \_\_\_\_\_  
Reason? \_\_\_\_\_

How many times in the past five years have you used Emergency Room Services? \_\_\_\_\_ When? \_\_\_\_\_  
Reason? \_\_\_\_\_

How many days in the past five years have you used sick leave (all employers)? \_\_\_\_\_ When? \_\_\_\_\_  
Reason? \_\_\_\_\_

Have You Ever:

Had any fractures or dislocations to your bones or joints?

Been injured in a traffic accident?

Injured your head?

Been injured in an assault or fight (not sports injuries)?

Been injured while drinking?

Yes

No

Alcohol or Drug related: Please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

◆ **ALCOHOL & DRUG USE HISTORY**

At what time in your life did you drink the most? From age \_\_\_\_\_ to age \_\_\_\_\_  
 At what time in your life did you use other drugs the most? From age \_\_\_\_\_ to age \_\_\_\_\_  
 In the past 12 months, have you:

Yes    No

- Needed noticeably increased amounts of alcohol or other drugs to achieve intoxication or desired effect?
- Experienced withdrawal symptoms, such as: sweats, shakes, insomnia, nausea or vomiting, hallucination or illusions, anxiety or seizures?
- Taken alcohol or other drugs in larger amounts or over a longer period than you intended?
- Had a persistent desire or unsuccessful efforts to cut down or control substance use?
- Spent a great deal of time obtaining or using alcohol or other drugs or recovering from the effects?
- Given up important social, work or recreational activities because of substance use?
- Continued to use alcohol or other drugs despite knowledge of a persistent physical or psychological problem that is caused Or made worse by such use?

Please complete the table below. List all substances (including alcohol).

List All Drugs Used	Age Of First Use	Age When Regular Use Began	Average Number Of Times Used Each Week (current)	Average Amount Used Each time	Usual Way Used (Oral, Smoked, Snorted, IM or IV)	Date Of Last Use
Beer						
Wine						
Liquor						
Nicotine						
Marijuana						
Cocaine						
Caffeine						
Amphetamines						
Benzodiazepines						
Opiate's						
Barbiturates						
Inhalants						
Hallucinogens						
Other Drugs						

Were any of the above drugs you used prescribed by a doctor or dentist?      Yes      No

Last 12 months:

Kind: \_\_\_\_\_

Amount: \_\_\_\_\_

Frequency: \_\_\_\_\_

◆ **ALCOHOL & DRUG USE HISTORY**

Has anyone in your family had any problems with alcohol or other drugs? (Children, parents, brothers and sisters, grandparents, uncles and aunts, cousins)      Yes      No

Who? \_\_\_\_\_ Was it treated? \_\_\_\_\_

Have you ever received education or treatment for alcoholism or drug addiction?      Yes      No

Where and when? \_\_\_\_\_

Have you ever attended a meeting of Alcoholics Anonymous, Narcotics Anonymous or any other support groups?      Yes      No

What, when? \_\_\_\_\_

What is the longest period of time you have gone without any alcohol or drug use? \_\_\_\_\_

When? \_\_\_\_\_ Why? \_\_\_\_\_ How? \_\_\_\_\_

When returning to use how long did you drink/use drugs? \_\_\_\_\_

How many attempts to stop or control use of alcohol or drugs have you experienced? \_\_\_\_\_

When did you return to drinking or using other drugs? \_\_\_\_\_

What led to your return to use of alcohol or drugs? \_\_\_\_\_

What motivates you to stop or discontinue Alcohol/Drug use at this time? \_\_\_\_\_

Do you think you have a problem with alcohol or other drugs?      Yes      No      Why or Why Not? \_\_\_\_\_

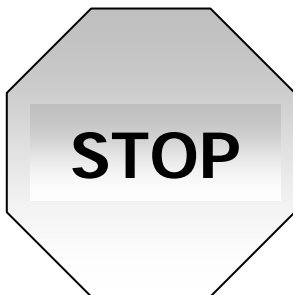
How important to you is it that you change your alcohol/drug use? \_\_\_\_\_

How confident are you that you will change your current drinking/drug use? \_\_\_\_\_

Would you like to reduce or stop your alcohol/drug use, if you could do so easily? \_\_\_\_\_

Are you worried about getting in more trouble from drinking or drug use in the future?      Yes      No

Have you ever stopped drinking, then started smoking marijuana or taking another drug, including prescription medications?  
Yes      No



Please return this questionnaire to a staff member as directed.  
Thank you!

◆ **COUNSELOR SUMMARY**

Patient Presentation (circle if all that apply)

Attitudinal Posture:

Defensive      Hostile      Arrogant      Passive      Defiant      Open

How Dressed: \_\_\_\_\_

Hygiene: \_\_\_\_\_

Orientation to Time, Place and Person:  Yes       No

Patient's Statement of the Incident: \_\_\_\_\_

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Analysis of Breath test report: \_\_\_\_\_

Analysis of Complete Driving Abstract and/or Defendant Criminal History:

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Analysis of Police: \_\_\_\_\_

Urine Drug Test results/analysis: \_\_\_\_\_

If a finding of abuse or dependence:

Any major barriers to treatment and/or recovery indicated at this time:

- 1.
- 2.
- 3.

Strengths/Assets:

- 1.
- 2.
- 3.

Major life situations to be aware of in treatment planning:

- 1.
- 2.
- 3.

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Name: \_\_\_\_\_ Date: \_\_\_\_\_