Youth Confidential Self-Evaluation

Barth Clinic
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PLEASE PRINT

Date of Evaluation _____ Patient ID Number _____

Name _____ Home Phone ( ) _____
First Last Nickname

Address _____ School Phone ( ) _____
Street • P.O. Box Apartment

Cell Phone ( ) _____

_____ Date of Birth _____
City State Zip Code Month • Day • Year

Drivers License, or permit # _____ State _____ Age_____

Social Security Number XXX – XX - _____Height_____ Weight _____ ☐ Male ☐ Female ☐ Gender Neutral
☐ Prefer Not to Answer ☐ Other:_____

Physician _____Phone ( )_____
Name City

Personal Contact: _____Phone ( )_____
Name Relationship City

Family Member:_____Phone ( )_____
Name Relationship City

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?

_____

What special needs or concerns should the staff be aware of for your assessment or treatment?_____

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

_____

♦FINANCIAL

Financial Status ☐ Good ☐ Fair ☐ Poor

Primary Payment Source for Treatment

☐ Insurance
☐ Private Pay
☐ Medicare
☐ CHAMPUS
☐ Title XIX
☐ Agency Funded
☐ Other

Insurance Company Name _____
Phone _____

Group Number _____

Subscriber Number _____

Subscriber Name _____

Housing ☐ Rent ☐ Own
Living with parents ☐
Monthly Payment $_____
Living w/ relatives _____
Other persons_____

Do you have significant financial stress at this time? ☐ Yes ☐ No
Do you have a history of gambling problems? ☐ Yes ☐ No
If yes, please explain:_____

♦ EDUCATION

Years of Education (Choose One) _____ or write in if more _____

Degree: None ☐ GED ☐ HS Diploma ☐

List Schools attended since Junior High:	Reason for leaving
1.	
2.	
3.	

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 When/Where? _____ _____

Did alcohol/drug use impact your educational goals? ☐ Yes ☐ No

♦ FAMILY

Marital Status

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

Who are you currently living with? _____
Name & Relationship

Does the person you are 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

What does your father do for a living?_____

What does your mother do for a living?_____

Number of Brothers _____

Number of Sisters _____

Your Birth Order? _____
1st, 2nd, etc.

Birth place _____
Place raised _____ Who raised you? _____
When did you leave Home & Why _____

Children:

Gender	Age	Name
_____	____	_____
_____	____	_____
_____	____	_____

Write additional children on the back of this page.

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

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

• If Native American/Eskimo/Alaska Native/Aleut, please provide tribal information>
Tribe or corporation _____
Tribal recognition ☐ Federal ☐ Non-Federal ☐ Canadian
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

♦LEGAL

Current Legal Problem _____ Date of Offense _____ BAC _____

Court _____ Judge _____ Case # _____

Court _____ Judge _____ Case # _____

Next Court Date _____ Case Status _____

Attorney Name _____ Phone # _____

Address _____

Probation Officer _____ Phone # _____

Do you have your driving abstract 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

Any Current or Former Gang Affiliation? ☐ Yes ☐ No If yes, please explain:_____
Are you a registered sex offender? ☐ Yes ☐ No Level?_____
Do you have an active restraining order? ☐ Yes ☐ No Names pf parties involved?_____

Are you under civil or criminal ordered mental health or substance use disorder treatment? ☐ Yes ☐ No

Is there a court order exempting your participation in reporting requirements? ☐ Yes ☐ No
(If so, court ordered documentation must be provided.)
Outstanding Warrants? ☐ Yes ☐ No What & When _____

Past Arrests or Convictions?

Charge	Date	Court	Final Outcome	BAC

Any charges dropped/dismissed? _____

♦EMPLOYMENT

☐ Employed Full-Time
☐ Employed Part-Time
☐ Self-Employed
☐ Student
☐ Disabled
☐ Public Assistance
☐ Unemployed (Seeking Work)
☐ Unemployed (Not Seeking Work)

Employer _____ Location _____
Length in Current
Employment _____ Monthly Income $_____
Position & Type of Work _____
Number of Employers _____ Location _____
In Past Five Years _____ With One Employer _____

If Unemployed, What is
Your Source of Income _____

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

♦ MEDICAL **(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) _____

Do you have any food/drug allergies? ☐ Yes ☐ No Please list:_____

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? _____

Is there any history of harm to self or others? ☐ Yes ☐ No
If yes, are you currently at risk? Please explain:_____
_____

Suicidal/Homicidal Ideation? ☐ Yes ☐ No
If yes, are you currently at risk? Please explain:_____
_____

Do you have a history of self harm? (example: cutting, burning, hitting, etc?) ☐ Yes ☐ No
If yes, are you currently at risk? Please explain:_____
_____

Have you ever experienced an overdose: Accidental? ☐ Yes ☐ No Purposeful? ☐ Yes ☐ No
If yes, please explain:_____

- If yes, was Narcan administered?_____

Additional Notes:

Have you or anyone in your family ever had or been diagnosed as having any of the following?

(Check NONE for questions that do not apply)

You	Family	None		You	Family	None	
☐	☐	☐	Alcoholism	☐	☐	☐	Loss of Appetite
☐	☐	☐	Anemia	☐	☐	☐	Mental Illness
☐	☐	☐	Asthma	☐	☐	☐	Morning nausea, vomiting
☐	☐	☐	Cirrhosis	☐	☐	☐	Night Sweats
☐	☐	☐	Depression	☐	☐	☐	Numbness in Fingers or Toes
☐	☐	☐	Diabetes	☐	☐	☐	Pancreatitis
☐	☐	☐	Drug Addiction	☐	☐	☐	Panic or anxiety attacks
☐	☐	☐	DT's	☐	☐	☐	Recurrent diarrhea
☐	☐	☐	Fainting	☐	☐	☐	Seizures
☐	☐	☐	Fatty Liver	☐	☐	☐	Shaking
☐	☐	☐	Gastro esophageal Reflux	☐	☐	☐	Significant weight loss or gain
☐	☐	☐	Head Injury	☐	☐	☐	Sleep problems
☐	☐	☐	Headache or Migraine	☐	☐	☐	Suicide
☐	☐	☐	Heart Problems	☐	☐	☐	TB
☐	☐	☐	Heartburn or gastritis	☐	☐	☐	Ulcers
☐	☐	☐	Hepatitis	☐	☐	☐	Use of Antabuse or Trexan
☐	☐	☐	High Blood Pressure	☐	☐	☐	Use of Prescription Drugs

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 been sick and missed school or work or both? _____ When?_____
Reason? _____

Have You Ever:	Yes	No	As a result of Alcohol/Drug use:	Please explain:
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?	☐	☐	☐	_____

♦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/Crack						
Caffeine						
Amphetamines (+ crank)						
Tranquilizers						
Opiate's						
Barbiturates						
Inhalants						
Hallucinogens						
Designer Drugs (Ecstasy, Etc.)						
Over the Counter (No Doze, Dramimine, Etc.)						
Other Drugs						

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

Did drinking or using drugs make you feel more talkative or social? ☐ Yes ☐ No

Did drinking or using drugs make you feel that you could do things that you normally couldn't do sober? ☐ Yes ☐ No

Did drinking or using drugs help you to forget about your problems? ☐ Yes ☐ No

Do you feel that drinking or using drugs was based on your own decision not influence by your friends? ☐ Yes ☐ No

Did the majority of your friends use alcohol or drugs? ☐ Yes ☐ No

Did most of your going out with friends involve alcohol or drug use? ☐ Yes ☐ No

Did you lie to parents, teachers or any other authority figures about your drug use? ☐ Yes ☐ No

Did you drink or use drugs after disagreements with family or friends? ☐ Yes ☐ No

Has your reputation been hurt by things that you did while drinking or using drugs? ☐ Yes ☐ No

Did you ever do or say something while drunk or high that you wished you could take back the next day? ☐ Yes ☐ No

Have you ever gone out saying I'm not going to use tonight and ended up using anyway? ☐ Yes ☐ No

Have you ever said one type of drug or alcohol makes you crazy so you just won't use that and use something else? ☐ Yes ☐ No

Have you ever noticed that it takes more of a drug or alcohol ot get you high than it use to? ☐ Yes ☐ No

Has anyone, including friends told you that you drink or use to much? ☐ Yes ☐ No

Have you ever gotten sick or felt burnt out after using and said, "I'll never do this again!" and ended up using again shortly thereafter? ☐ Yes ☐ No

Have you ever drank or used drugs to make yourself feel better after a rough night? ☐ Yes ☐ No

Has your education been affected in anyway by your drug or alcohol use (including skipping school, grades dropped, getting caught at school with drugs or alcohol? ☐ Yes ☐ No

Have you ever placed yourself in a dangerous situation while drinking or drugging (includes fights, driving or riding in a car while someone has been using.) ☐ Yes ☐ No

Have you ever stolen money from parents or family members for drugs or alcohol? ☐ Yes ☐ No

Have you ever committed any crimes while using or straight due to your use or to obtain chemicals for your use? ☐ Yes ☐ No

Have you ever thought about suicide while high or over something you did while using? ☐ Yes ☐ No

Have you ever experienced extreme paranoia while high (thinking others are talking behind your back or trying to get you in one way or another)? ☐ Yes ☐ No

♦ALCOHOL & DRUG USE HISTORY

Has anyone in your immediate family had any problems with alcohol or other drugs? (children, parents, brothers and sisters, grandparents, uncles and aunts, cousins) ☐ Yes ☐ No
Who? _____ Where? _____

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

If you have, where and when? _____

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

If you have, when? _____

What is the longest period of time you have gone without drinking or drugging? _____

When? _____ Why? _____

How did it feel? _____
_____

How did you do it? _____

When did you return to drinking or using? _____
_____

Why? _____

Do you think you have a problem with alcohol or other drugs? ☐ Yes ☐ No Why? Or Why Not?_
Do you now live in a place that is free of alcohol and drugs? ☐ 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 _____

_____

Other family questions: _____

Parent or sibling Alcohol/Drug use: _____

Did your parents drink, smoke or use drugs when you were younger or before your birth? _____

Who do you live with? (Name/relationship)_____

Have you ever been in: Foster care_____ Group Home_____ Other institution _____

Did you ever run away for a day or more? _____ If so, for how long & where did you go? _____

Who is your closest friend outside of your family?_____

What would you change about your family if you could?_____

What do you like about where you live?_____

Would your parents/guardians be willing to participate in treatment? _____

Are there any other supportive adults in your life? _____ If so, who? _____

Please stop on this page and go on to the next questionnaire!
Thank you.

FOR COUNSELOR USE ONLY

♦MENTAL

	Yes	No
Cooperative	☐	☐
Uncooperative	☐	☐
Friendly	☐	☐
Hostile	☐	☐
Open	☐	☐
Defensive	☐	☐
Guarded	☐	☐
Honest	☐	☐
Closed	☐	☐

How Dressed: _____

Hygiene _____

Orientation to Time, Place and Person: ☐ Yes ☐ No

Urine Drug Testing: ☐ Yes ☐ No

Patient's Statement of the Incident:

_____

_____

Parent Interview/Family questions:

Have there been any custodial issues (child custody battle, running away, foster care or institutional living)?

Is there substance use in the home by parents/siblings? _____

Was there substance use from either parent during adolescence or the pregnancy?

Have there ever been any emotional problems, developmental problems or learning problems?

Are the parents able and willing to participate in treatment with the patient if it is indicated?

Substance Use Disorder: _____ Mild _____ Moderate _____Severe

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.

Name: Signature: Date: