Confidential Self-Evaluation

Barth Clinic of Central Washington
P.O. Box 1207
Yakima, WA 98907
Toll free (877) 457-5657

www.barthclinic.com

PLEASE PRINT

Date of Evaluation: _____ Patient ID Number: _____

Name: _____ Email:_____
First Middle Last

Home Phone: _____

Address: _____ Work Phone: _____
Cell Phone: _____

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

Drivers License # _____ State: _____Age:_____

Social Security Number:_____-_____-_____Height_____ Weight _____

☐ Male ☐ Female ☐ Transgender ☐ Neutral ☐ Prefer Not to Answer ☐ Other:_____

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	School	Yellow Pages
Chemical Dependency Agency/Detox	Mental Health Counselor	Family Member
Physician or Hospital	Native American Tribe	Friend
Insurance Company/Managed Care	Other	Former Patient/Alumni
Employer/EAP/Union		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
☐ Black/African American
☐ Native American •
☐ Eskimo/Alaskan Native•
☐ Aleut •
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Korean
☐ Vietnamese
☐ Japanese
☐ Samoan
☐ Asian India
☐ Guamanian
☐ 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

♦ FAMILY

Marital Status

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

Who are you currently living with?_____

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 _____
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
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

♦ EDUCATION

Years of Education (Pick One) 5th Grade or write in if more _____

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

	Yes	No	
Military Service?	☐	☐	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
☐ Employed Part-Time
☐ Self-Employed
☐ Military
☐ Student
☐ Homemaker
☐ Retired
☐ Disabled
☐ Public Assistance
☐ Unemployed (Seeking Work)
☐ Unemployed (Not Seeking Work)

Employer _____Location _____

Length in Current Employment _____

Position & Type of Work _____

Number of Employers In Past Five Years _____ Longest Time 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

♦FINANCIAL

Financial Status ☐ Good ☐ Fair ☐ Poor

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

Insurance Company Name _____

Phone _____

Group Number _____

Subscriber Number _____

Subscriber Name _____

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:_____

♦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

Any Current or Former Gang Affiliation? ☐ Yes ☐ No If yes, please explain: _____

Are you a registered sex offender? Yes No If yes, what level?_____

Do you have an active restraining order? Yes No Names of 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

♦ 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 have any food/drug allergies? Yes No If so, what are they?_____

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?_____

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		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	☐	☐	☐	Anxiety or Nervousness
☐	☐	☐	Delirium Tremens	☐	☐	☐	Recurrent diarrhea
☐	☐	☐	Fainting	☐	☐	☐	Seizures
☐	☐	☐	Fatty Liver	☐	☐	☐	Shaking
☐	☐	☐	Gastro esophageal Reflux	☐	☐	☐	Significant weight loss or gain
☐	☐	☐	Head Injury	☐	☐	☐	Sleep problems
☐	☐	☐	Headache or Migraine	☐	☐	☐	Suicide attempts or plans
☐	☐	☐	Heart Problems	☐	☐	☐	TB
☐	☐	☐	Heartburn or gastritis	☐	☐	☐	Ulcers
☐	☐	☐	Hepatitis	☐	☐	☐	Physical, sexual or emotional abuse
☐	☐	☐	High Blood Pressure	☐	☐	☐	Obsessive, compulsive behaviors
☐	☐	☐	ADD/ADHD	☐	☐	☐	Other:
☐	☐	☐	Eating Disorder				

Have you ever been told you are pre diabetic or diabetic?_____Are you on medication?_____
If you marked yes for Diabetes, Do you know your A1C_____Are you on insulin or metformin?_____
Are you being treated for your diabetes?_____Do you need assistance finding a Dr?._____

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? _____

Have You Ever:	Yes	No	Alcohol or Drug related:	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 _____
Have you ever used drugs Intravenously? ☐ Yes ☐ No
If yes, What age did you begin?_____How long did you continue?_____
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						
Methadone						
Other Drugs						

Were any of the above drugs you used prescribed by a doctor or dentist in the past 12 months? ☐ Yes ☐ No
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?_____

_____

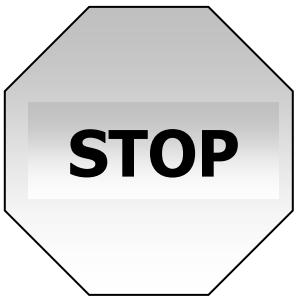
How important to you is it that you change your alcohol/drug use? _____

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

If you could do so easily, would you like to reduce or stop your alcohol/drug use? _____

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 continue on to next questionnaire.
Thank you!

♦COUNSELOR SUMMARY

For Counselor Use only

Patient Presentation (check 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: _____

_____

_____

_____

_____

_____

Analysis of Breath test report:_____

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

_____

_____

Analysis of Police: _____

Urine Drug Test results/analysis:_____

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: _____ Date: _____

X111 Barth Clinic Confidential Self-Evaluation 2/3/2023 revised