Your Client's Number _____

Solutions Outpatient Services

FAMILY PROGRAM QUESTIONNAIRE

Research has shown that when family members are educated and engaged in their own recovery and growth process, the chemically dependent person's chances of successful recovery increase.

_____ is a client at Solutions Outpatient Services for treatment of substance abuse/dependence disorders and has given us permission to contact you. Your knowledge of the client can assist us in identifying the problem areas and needs of the client and to plan the program that will be most helpful. Please return this form within **48 hours** of receiving it. Please be honest with yourself. This information will **only** be discussed with the treatment team. Thank you.

Another reason for contacting you is to invite you to Family Weekend on _____. Your client's counselor will be Mary Donna Noack, MA, LPC, LCDC, Lois Jordan, LCSW, LCDC, or Leonard Keesee, RN, LCDC, NCAC II. You need to confirm your participation in Family Weekend with his/her counselor or the Office Manager Deborah Huber at the following number (214) 369-1155. The Family Program also offers family lecture and groups on Tuesday and Thursday nights. Please inform us of your participation in The Family Program. Participation is so important.

Identification & Current Living Circumstances

Your Client's Name _____ Your Name _____

Today's Date _____/_____/_____ Your Age _____ Who Referred You/ Your Client to Solutions _____

Address _____ Apt.# _____ Cell Phone _____

City _____ State _____ Zip _____ Home or Work Phone _____

Email _____ Place of Employment/School_____

Ethnicity

- ❑ Anglo
- ❑ African-American
- ❑ Native American
- ❑ Hispanic-American
- ❑ Asian-American
- _____

Gender

❑ Male ❑ Female

Current Family Members

Parents _____
Partner _____
Siblings _____
Children_____

Marital/Relationship Status

- ❑ Never Married
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed
- ❑ Committed Relationship
- ❑ Not in a Relationship Currently

What is Your Relationship to the Client

- ❑ Mother/Father
- ❑ Daughter/Son
- ❑ Sister/Brother
- ❑ Grandparent
- ❑ Uncle/Aunt
- ❑ Spouse/Partner
- ❑ In-Law
- ❑ Friend
- ❑ Sponsor
- ❑ _____

Are You Living with the Client ❑ No ❑ Yes If Yes, How Many Years ____ How Many Years in This Relationship _____

Your Prescription Drug Use History

Use Back of Sheet if Needed

Medication Name/Strength	Route	Dose	Purpose	Date Started	Date Stopped	Prescribing Physician

Your Alcohol & Illicit Drug Use History

Substance	Slang/ Nickname/ Variations	Age First Used	Method Taken	Amount Used	How Often	Number of Years Used	Date Last Used
Alcohol Use	Booze, Liquor, Spirits						
Cannabis Use **Synthetic Marijuana**	Weed, Pot, Grass, THC, Marijuana, Primos, Hashish, Hash Hash Oil, , etc. K2, Spice, Fake Week						
Phencyclidine Use	PCP, Angle Dust, Ketamine						
Other Hallucinogen Use	Mescaline, DOM, MDMA (Ecstasy), Psilocybin, DMT, DET, LSD, Salvia, Mushrooms, Morning Glory Seeds, Fry						
Inhalant Use	Gasoline, Glue, Liquid Paper, Paint Thinner, Hair Spray, Duster						
Opioid Use	Heroin, Codeine, Darvon, Darvocet, Percocet, Percodan, Oxytocin, Dilaudid, Demerol, Hydrocodone Lorcet, Lortab, Vicodin, Fiorinal						
Methadone	Delophine, Methadose, Dome, Medicine						
Sedative, **Hypnotic**, **& Anxiolytic Use Benzodiazepines & Barbiturates**	Diazepam, Librium, Valium, Dalmane, Tranks, Rohypnol, Ativan, Halcion, Xanax, Serax, GHB, Lorazepam						
	Seconal, Nembutal, Stumblers, Methaqualone Downers, Goofballs, Tuinal, Phenobarbital, Reds						
Stimulant Use (Amphetamine-type)	Amphetamine, Crystal, Ice, Crank Dextroamphetamine, Mini-Thins, Methamphetamine, Ritalin, Meth Methlphenidate, *khat*, Dexedrine,						
Stimulant Use (Cocaine)	Coke, Powder, Flake, Snow, Crack, Rock, Speedballs (w/ Heroin)						
Stimulant Use (Other/Unspecified)							
Tobacco Use	Cigarettes, Smokeless Tobacco, Snuff, Cigars, Chew						
Other (or Unknown) Use	Cough Syrup, Robitussin, Nyquil Coricidin, Triple C						
Anything Else You Have Used							

Have Other Family Member Used or Abused Any of the Above Drugs ❑ No ❑ Yes Who _____

Explain _____

_____

_____

There Will Be Another Section Which Will Allow You to Go Into Detail Regarding your Concerns with Your Client/Loved One.

Your Medical History

Check Those You Have Had or Have Experienced

❑ Headaches	❑ Facial Numbness	❑ Difficulty Seeing	❑ Weakness, Tiredness
❑ Difficulty Reading	❑ Numbness	❑ Do You Wear Glasses	❑ Difficulty With Coordination
❑ Difficulty Hearing	❑ Limited Movement	❑ Do You Use A Hearing Aid	❑ Loss of Sleep
❑ Frequent Colds	❑ Muscle Cramps	❑ Dizziness	❑ Frequent Indigestion
❑ Neck/Shoulder/Back Pain	❑ Joint Pain	❑ Difficulty Swallowing	❑ Frequency in Urination
❑ Heartburn or Gas	❑ Nausea or Retching	❑ Constipation	❑ Vomiting
❑ Diarrhea	❑ Chest Pain	❑ Shortness of Breath	❑ Palpitations
❑ Abdominal Pain	❑ Loss of Appetite	❑ Recent Weight Gain	❑ Recent Weight Loss
❑ Liver Problems	❑ Vomiting Blood	❑ High Blood Pressure	❑ Ankle Swelling
❑ Cough	❑ Cancer	❑ Heart Problems	❑ Stroke
❑ Ulcers	❑ Kidney Problems	❑ Type 1 Diabetes	❑ Type 2 Diabetes

❑ Other_____

Family Medical History _____

_____

_____

Your Treatment & Counseling History

Use Back of Sheet if Needed

I. Prior Chemical Dependency Treatment for You (Number of Times): _____

1. Where _____ When_____ Length of Stay_____

Successful Completion ❑ Yes ❑ No Reason for Discharge _____

II. Prior Eating Disorder Treatment for You (Number of Times): _____

1. Where _____ When_____ Length of Stay_____

Successful Completion ❑ Yes ❑ No Reason for Discharge _____

III. Prior Codependency Treatment or Intensive Week Treatments for You (i.e. Survivors Workshop) (Number of Times) _____

1. Where _____ When:_____ Name of Workshop _____

Successful Completion ❑ Yes ❑ No Reason for Discharge _____

IV. Prior Psychiatric Treatment for You (Number of Times): _____

1. Where _____ When _____ Length of Stay _____

Successful Completion ❑ Yes ❑ No Reason for Discharge _____

V. Prior Counseling or Therapy for You (Number of Times): _____

With Whom _____ For What _____How Long_____

Your Family of Origin History

YOUR FATHER _____

Current Age or Age at Death _____

Cause of Death _____

Occupation _____

Has or Has Ever Had a Problem With

- ❑ Alcohol/Drugs
- ❑ Eating Disorders
- ❑ Money Disorders
- ❑ Sex & Love Addiction
- ❑ Mental Illness
- ❑ Serious Medical Illness

Explain _____

Describe Personality of Father

_____

YOUR MOTHER _____

Current Age or Age at Death _____

Cause of Death _____

Occupation _____

Has or Has Ever Had a Problem With

- ❑ Alcohol/Drugs
- ❑ Eating Disorders
- ❑ Money Disorders
- ❑ Codependency
- ❑ Mental Illness
- ❑ Serious Medical Illness

Explain _____

Describe Personality of Mother

_____

YOUR STEP-FATHER _____

Current Age or Age at Death _____

Cause of Death _____

Occupation _____

Has or Has Ever Had a Problem With

- ❑ Alcohol/Drugs
- ❑ Eating Disorders
- ❑ Money Disorders
- ❑ Sex & Love Addiction
- ❑ Mental Illness
- ❑ Serious Medical Illness

Explain _____

Describe Personality of Step-Father

_____

YOUR STEP-MOTHER _____

Current Age or Age at Death _____

Cause of Death _____

Occupation _____

Has or Has Ever Had a Problem With

- ❑ Alcohol/Drugs
- ❑ Eating Disorders
- ❑ Money Disorders
- ❑ Codependency
- ❑ Mental Illness
- ❑ Serious Medical Illness

Explain _____

Describe Personality of Step-Mother

_____

What Was the Nature of Your Parent's Relationship _____

_____

What Were the Most Important Family Values _____

Yours & Your Family Member's 12 Step Involvement & Treatment History

Name	Relationship To You	Treatment History (Where & When)	History of 12 Step Involvement	Current 12 Step Involvement	Current Recovery/ Sober (Y/N)	Comments

Your Childhood & Adolescence History

Place of Birth _____ Where Were You Raised _____

Raised In ❑ Rural ❑ Suburban ❑ Urban ❑ Other _____

Primarily Raised By ❑ Parent(s) ❑ Grandparent(s) ❑ Sibling(s) ❑ Aunt(s)/Uncle(s) ❑ Cousin(s) ❑ Foster parent(s)

Other _____

Describe Relationships Within The Family _____

_____

_____

Number of People in Family During Childhood/Adolescence _____

Felt Closest To ❑ Parent(s) ❑ Grandparent(s) ❑ Sibling(s) ❑ Aunt(s)/Uncle(s) ❑ Cousin(s) ❑ Foster Parent(s)

Other _____

Why _____

Did You or Any of Your Siblings Experience any Type of Abuse Growing Up ❑ No ❑ Yes If Yes, Please Explain

_____

_____

_____

What Form of Punishment was Usually Used in your Family Growing Up and by Whom _____

_____

What was Your Family's Attitude toward Alcohol/Drugs Growing Up _____

_____

Your Marital History and Current Family History

Number of Marriages _____ List Age at Each Marriage and Reason for Divorce

1st Divorce Your Age _____ Reason _____ 2nd Divorce Your Age _____ Reason _____

3rd Divorce Your Age _____ Reason _____ 4th Divorce Your Age _____ Reason _____

Quality of Relationship With Your Present Partner ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Describe _____

Was Alcohol and/or Drug Use Involved in Divorces/Separations ❑ No ❑ Yes Comment _____

_____

SPOUSES/SIGNIFICANT RELATIONSHIPS In Descending Order Include Deceased Spouses. Use Back of Page if Needed

 # 1 SPOUSE/SIGNIFICANT RELATIONSHIP

Name _____

Dates of Marriage Inclusive/Relationship _____

Current Age or Age at Death _____

#2 SPOUSE/SIGNIFICANT RELATIONSHIP

Name _____

Dates of Marriage/Relationship Inclusive _____

Current Age or Age at Death _____

Cause of Death _____ Cause of Death _____

Personality _____ Personality _____

Describe Relationship _____ Describe Relationship _____

_____ _____

 # 3 SPOUSE/SIGNIFICANT RELATIONSHIP **#4 SPOUSE/SIGNIFICANT RELATIONSHIP**

Name _____ Name _____

Dates of Marriage/Relationship Inclusive _____ Dates of Marriage/Relationship Inclusive _____

Current Age or Age at Death _____ Current Age or Age at Death _____

Cause of Death _____ Cause of Death _____

Personality _____ Personality _____

Describe Relationship _____ Describe Relationship _____

_____ _____

CHILDREN In Descending Order. Beginning with the Oldest. Include Deceased Children.

 # 1 CHILD OR STEP CHILD **#2 CHILD OR STEP CHILD**

Name _____ Name _____

Current Age or Age at Death _____ Current Age or Age at Death _____

Cause of Death _____ Cause of Death _____

Personality _____ Personality _____

Describe Relationship _____ Describe Relationship _____

_____ _____

 # 3 CHILD OR STEP CHILD **#4 CHILD OR STEP CHILD**

Name _____ Name _____

Current Age or Age at Death _____ Current Age or Age at Death _____

Cause of Death _____ Cause of Death _____

Personality _____ Personality _____

Describe Relationship _____ Describe Relationship _____

_____ _____

Your Emotional & Mental Health History

How Do You Picture Yourself Describe Yourself in Your Own Words

_____

_____

Do You Have Fears, or Anxieties About Anything ❑ No ❑ Yes If Yes, Please Explain _____

_____

Do You Become Intensely Involved in Relationships ❑ No ❑ Yes Explain _____

Are Relationships Short-Lived ❑ No ❑ Yes Comment _____

Do You Have Difficulty Being Alone ❑ No ❑ Yes Comment _____

Do You Experience Intense Anger ❑ No ❑ Yes Comment _____

Do You Have Difficulty Expressing Anger ❑ No ❑ Yes Comment _____

Do You Have Trouble Maintaining Friendships ❑ No ❑ Yes If Yes, Please Explain _____

_____

Do You Have Any of the Behaviors and Attitudes Described Below ❑ No ❑ Yes If Yes, Please Explain

- ❑ Perfectionism _____
- ❑ Low Self-Esteem _____
- ❑ Needs to Control Others _____

❑ Lack of Expression of Feelings_____
❑ Need to Always be Right_____
❑ Depression _____
❑ Difficulty Making Decisions/Choices_____

Have You Isolated From Family, Friends, or Social Involvement ❑ No ❑ Yes Please Explain _____
_____

Do You Apologize More Often for Your Behavior ❑ No ❑ Yes Please Explain _____
_____

Have You Changed Jobs, School, Friends, Habits, etc. in an Effort to "Make Things Better" ❑ No ❑ Yes If Yes, Please Explain
_____

Have You Covered Up for Someone Else's Behavior ❑ No ❑ Yes Please Explain _____
_____

Has Your Care for Personal Appearance Changed ❑ No ❑ Yes Please Explain _____
_____

Do You Blame Other People, Places or Things for Difficulties Experienced ❑ No ❑ Yes Please Explain _____
_____

Do You Experience Mood Swings ❑ No ❑ Yes Please Explain _____
_____

Do You Seem to Have an Over-Developed Sense of Responsibility for Others ❑ No ❑ Yes Please Explain _____
_____

Do You Seem to Experience Over Sensitivity to Personal Criticism ❑ No ❑ Yes Please Explain _____

Have You Been Diagnosed/Struggled with a Sexual Addiction ❑ No ❑ Yes Comment _____

Have You Been Diagnosed/Struggled with a Love Addiction ❑ No ❑ Yes Comment _____

Have You Been Diagnosed/Struggled with a Debting Disorder ❑ No ❑ Yes Comment _____

Have You Been Diagnosed/Struggled with a Gambling Addiction ❑ No ❑ Yes Comment _____

Have You Been Diagnosed with a Mental Disorder ❑ No ❑ Yes Comment Below

❑ Depression (When) _____
❑ Anxiety/PTSD (When) _____
❑ ADHD/ADD (When) _____
❑ Bi-Polar (When) _____
❑ Schizophrenia (When) _____
❑ Dissociative Disorder (When)_____
❑ Personality Disorder (When) _____
❑ Borderline ❑ Narcissist ❑ Dependent ❑ Paranoid ❑ Schizoid ❑ Antisocial ❑ Histrionic ❑ Avoidant
❑ Other (What & When)_____

Have There Been Verbal Threats or Name Calling in Your Home ❑ No ❑ Yes Comment _____

Have You or a Family Member Ever Had a History of Violent and/or Self-Harm Behavior (Cutting, Inflicting Injury to Yourself)

❑ No ❑ Yes Comments _____

What Form of Punishment Was/Is Used in Your Current Family Comment _____

Are There Fire Arms in the Home ❑ No ❑ Yes, If Yes Where Do You Keep Them _____

Do You Keep Them Locked ❑ No ❑ Yes Comment _____

Have You or a Family Member Ever Had . . .

Suicidal Attempts	Suicidal Plans	Suicidal Thoughts
❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
How Many Suicide Attempts _____	Last Attempt _____	Alcohol/Drug Related ❑ No ❑ Yes

Comments _____

Your Abuse History (Physical, Sexual, Emotional, Mental, Spiritual, Financial, Etc.)

PHYSICAL ABUSE – Includes ❑ Face Slapping ❑ Shaking a Child ❑ Hair Pulling ❑ Head Banging ❑ Tickling Into Hysteria
❑ Lack of Appropriate Physical Nurturing ❑ Intrusive Procedures ❑ Hitting with an Object

Have You Ever Been Physically Abused ❑ No ❑ Yes Check All Above That Apply

What Happened _____

_____

SEXUAL ABUSE – Includes – Any Form of Non-Consenting Sexual Activity with an Adult and in Childhood

Overt-Sexual Abuse

❑ Physical-Sexual Abuse
❑ Masturbation of a Child, Having a Child Masturbate an Adult ❑ Voyeurism ❑ Exhibitionism
❑ Sexual Intercourse ❑ Oral Sex ❑ Sexual Kissing ❑ Sexual Hugging
❑ Sexual Touching/Fondling ❑ Verbal Sexual Abuse ❑ Pornography ❑ Anal Sex

Covert-Sexual Abuse

❑ When a Parent or Caregiver Does Not Set Appropriate Sexual Boundaries with a Child
❑ When a Child Witnesses Sexual Abuse
❑ Emotional-Sexual Abuse (Emotional Enmeshment by the Parent or Caregiver)

Have You Ever Been Sexually Abused ❑ No ❑ Yes Check All Above That Apply

What Happened _____

_____

EMOTIONAL ABUSE – Is When a Major Caregiver Refuses to Allow a Child to Express Feelings, Shames a Child for His/Her Feelings or Demonstrates Improper Expression of His/Her Feelings in Front of the Child

Have You Ever Been Emotionally Abused ❑ No ❑ Yes

What Happened _____

_____

MENTAL ABUSE – Includes Attacks to a Child's Thinking Process, Over-Control of the Expression of a Child's Thoughts and Failure on the Part of a Major Caregiver to Teach Logical Thinking and Problem Solving.

Have You Ever Been Mentally Abused ❑ No ❑ Yes

What Happened _____

SPIRITUAL ABUSE – The Parent or Major Caregiver May Be a Religious Addict or the Child May be Abused by a Religious Leader. Spiritual Abuse Also Occurs When a Parent or Major Caregiver Does Not Follow the Established Family Rules or Values as Though He/She is Above Those Rules and Values.

❑ Being Disrespectful of a Child's Reality ❑ Demanding Perfection ❑ Neglecting ❑ Over-Controlling
❑ Demanding to be a Child's Higher Power ❑ Abandoning or Indulging a Child ❑ Ignoring

Have You Ever Been Spiritually Abused ❑ No ❑ Yes

What Happened _____

FINANCIAL ABUSE – Is When a Parent, Major Caregiver, Friend, or Authority Figure Takes Advantage of You for Financial Gain.

Have You Ever Been Financially Abused ❑ No ❑ Yes

What Happened _____

OTHER TYPES of ABUSE – Includes Peer or Social Abuse for Reasons of Race, Religion, Sexuality, and/or Physical Appearance.

Other Types of Abuse _____

Your Activities & Social History

Number of Close Friends _____

The Quality of My Relationships With My Friends is _____

List Clubs or Organizations That you Belong to _____

List Games or Sports you are Most Interested in _____

List Your Creative Interests _____

List Recreational Events You Enjoy (Movies, Symphony, Sports) _____

List Musical Interests _____

Any Special Talents or Skills _____

How Much are You Involved in Any of the Above _____

Your Educational & Vocational History

What is the Highest Level of Education Completed _____ Was School a Positive or Negative Experience _____

What is Your Present Job _____ How Long (In Years) _____ Do You Enjoy Your Job ❑ No ❑ Yes

Your Legal History

Number of Times Ever Arrested _____ Explain _____

Number of Times Charged _____ Explain _____

Number of Convictions _____ Explain _____

Age at First Arrest _____ Explain _____

Age at Last Arrest _____ Explain _____

Have You Had Any Legal Problems in Any of These Areas in the Past Two Years

❑ Driving ❑ Family ❑ Fights ❑ Financial ❑ DWI or DUI ❑ MIP ❑ PI ❑ Burglary ❑ Theft
❑ Other _____

In the Past Two Years, Have you Been Convicted of Any Offenses ❑ No ❑ Yes If Yes, Explain _____

_____

Are You Currently Involved in Any of These Legal Situations ❑ Divorce Proceedings ❑ Child Care/Custody Action

❑ Probation ❑ Civil Proceedings ❑ Parole ❑ Other _____

Name of P.O. _____ Phone number _____

Your Financial History

Do You or any Family Member Gamble ❑ No ❑ Yes If Yes, Describe _____

_____

Has Your Income Increased / Decreased / Stayed the Same in the Last Two Years _____

If Married, is Your Spouse Currently Employed ❑ No ❑ Yes If Yes, Where _____

_____

Who Contributes Income to Your Family _____ Who Controls Finances in Your Family _____

Do You Have Any Debt Currently, Including Credit Cards ❑ No ❑ Yes If Yes, Please Estimate Total Debt _____

Your Faith/Spiritual History

Average Number of Times you Attend Religious Services Per Month _____

What Religion Were you Primarily Raised in ❑ None ❑ Protestant ❑ Catholic ❑ Jewish ❑ Other_____

How Active Were You in That Religion _____

What Religion Are you Now ❑ None ❑ Protestant ❑ Catholic ❑ Jewish ❑ Other_____

Do You Believe in God ❑ No ❑ Yes If Yes, Rate Your Relationship With God _____ 0 = Non Existent to 10 = Existent

Spirituality Encompasses Our Connection with a Higher Power, Nature, Others, and Self. Check Spiritual Practices You Use:
❑ Prayer ❑ Meditation ❑ Journaling ❑ Reading Books on Spirituality ❑ Gardening ❑ Art
❑ Communion with Nature ❑ Yoga ❑ Other_____

What are Your Present Spiritual Problems or Needs_____

_____

THIS INFORMATION IS ABOUT YOUR CLIENT IN SOLUTIONS

Your Client's Alcohol & Drug History (To the Best of Your Knowledge)

Check the Boxes to the Drugs you Believe Your Client Uses or Has Used and Add Any Comments

- ❑ Alcohol _____
- ❑ Cocaine_____
- ❑ Crack_____
- ❑ Marijuana_____
- ❑ Amphetamines (Including Adderall, Ritalin, etc.) _____
- ❑ Tranquilizers (Xanax, Valium, Ativan, etc.)_____
- ❑ Sedatives_____
- ❑ Hallucinogens (LSD, ACID, Mushrooms, etc,) _____

Has He/She Experienced ❑ No ❑ Yes If Yes, Explain

- ❑ Blackouts _____
- ❑ Passing Out_____
- ❑ Shakes _____
- ❑ Sweats _____
- ❑ Other_____

Has the Use of Chemicals Become His/Her First Priority in Their Life ❑ No ❑ Yes If Yes, Explain _____

_____

Has He/She Ever Rationalized or Excused His/Her Chemicals ❑ No ❑ Yes If Yes, Explain _____

_____

Have Any Significant Others – Spouse, Friends, Children, Parents, Employer, etc. – Terminated or Threatened to Terminate Their Relationship if He/She Did Not Control, Cut Back or Stop His/Her Use of Chemicals ❑ No ❑ Yes If Yes, Explain

_____

_____

Has His/Her Usage of Chemicals Affected the Family ❑ No ❑ Yes If Yes, Explain _____

_____

Does He/She Go on Binges ❑ No ❑ Yes If Yes, Explain _____

_____

Has His/Her Behavior Become Unpredictable on the Job, at Home, in School or in Social Settings with Friends ❑ No ❑ Yes

Explain _____

_____

Has He/She Ever Talked of Suicide, Planned Suicide, or Attempted Suicide ❑ No ❑ Yes If Yes, Describe & Give Dates

_____

_____

Has He/She Ever Received Any Alcohol/Drug/Eating Disorder and/or Psychiatric Treatment in the Past

For What (Addiction)	When	Where	Successfully Completed It	12 Step Involvement		Comments

Your Client's Other Addictions and Mental/Emotional Health

Does Your Loved One/Client have a Problem with Food ❑ No ❑ Yes If Yes, Please Explain

- ❑ Obesity_____
- ❑ Obsessed with Weight Gain or Loss_____
- ❑ Refusing to Eat_____
- ❑ Over-Exercising to Stay Slim _____
- ❑ Uses Laxatives Regularly_____
- ❑ Vomiting After Meals _____
- ❑ Other _____

Does He/She Have a Problem with Work Addiction ❑ No ❑ Yes Please Describe How This Affected You and Your Family

_____

Please Describe Their Work/School Related Behavior _____

_____

Do you Believe That He/She Could Have a Problem with Any of the Following ❑ No ❑ Yes If Yes, Please Explain

- ❑ Gambling _____
- ❑ Compulsive Spending _____
- ❑ Debting_____
- ❑ Relationships/Sex_____
- ❑ Irresponsibility_____
- ❑ Vomiting After Meals_____
- ❑ Other_____

Has He/She Ever Been Sexually, Physically, or Verbally Abusive with a Spouse, Child, Sibling, Parent ❑ No ❑ Yes, Please Explain

_____

_____

Do You Believe He/She is Suffering from Other Addictions Not Mentioned Above ❑ No ❑ Yes If Yes, Please Explain

_____

_____

Has Your Client Ever Been Diagnosed with a Mental Disorder ❑ No ❑ Yes Please Explain

- ❑ Depression (When) _____
- ❑ Anxiety/PTSD (When) _____
- ❑ ADHD/ADD (When) _____
- ❑ Bi-Polar (When) _____
- ❑ Schizophrenia (When) _____
- ❑ Dissociative Disorder (When)_____
  - ❑ Borderline ❑ Narcissist ❑ Dependent ❑ Paranoid ❑ Schizoid ❑ Antisocial ❑ Histrionic ❑ Avoidant
- ❑ Other (What & When)_____

Codependency

Does Your Loved One/Client Have Trouble Maintaining Friendships ❑ No ❑ Yes If Yes, Please Explain_____

_____

Have You Noticed Any of the Behaviors and Attitudes Described Below in the Client ❑ No ❑ Yes If Yes, Please Explain

- ❑ Perfectionism_____
- ❑ Low Self-Esteem_____
- ❑ Needs to Control Others _____
- ❑ Lack of Expression of Feelings _____
- ❑ Need to Always be Right_____
- ❑ Depression _____
- ❑ Difficulty Making Decisions/Choices_____

Has He/She Isolated From Family, Friends, or Social Involvement ❑ No ❑ Yes Please Explain _____

_____

Does He/She Apologize More Often for His/Her Behavior ❑ No ❑ Yes Please Explain _____

_____

Has He/She Changed Jobs, School, Friends, Habits, etc. in an Effort to "Make Things Better" ❑ No ❑ Yes If Yes, Please Explain

_____

Has He/She Covered Up for Someone Else's Behavior ❑ No ❑ Yes Please Explain _____

Has His/Her Care for Personal Appearance Changed ❑ No ❑ Yes Please Explain _____

Does He/She Blame Other People, Places or Things for Difficulties Experienced ❑ No ❑ Yes Please Explain _____

Does He/She Experience Mood Swings ❑ No ❑ Yes Please Explain _____

Does He/She Seem to Have an Over-Developed Sense of Responsibility for Others ❑ No ❑ Yes Please Explain _____

Does He/She Seem to Experience Over Sensitivity to Personal Criticism ❑ No ❑ Yes Please Explain _____

Why Do You Think Your Loved One/Client Came to Treatment _____

Is there Any Additional Information You Think we Should Know in Order to Help Your Loved One/Client

The Following Exercise Will Help You Identify the Feelings You Have About Your Client's Behavior.
All of This Information Will be Held in Confidence and Not Made Available to Your Client Without Your Consent.

I Felt Angry About:

I was Afraid When:

I Felt Hurt About:

I Felt Ashamed:

I Felt Embarassed When:

I Felt Guilty About:

I Felt Sad About:

I Felt Lonely When:

I Felt Terror When/About:

I Felt Pain About:

I Felt Helpless When:

I Felt Hopeless When:

I Felt Neglected When:

I Felt Humiliated When:

I Felt Unimportant When:

Any Additional Comments You May Have _____

Updated 9/1/16