Andrea Morganstein, LPC, LLC **CLIENT COMPLETED** **Adult/Teen**

BACKGROUND SCREENING

Client Legal Name: _____ Date of Assessment:_____

Identity

What name would you like me to call you? _____

What pronouns would you like me to use if I refer to you in the third person?

he/him/his she/her/hers Other: _____

How do you identify yourself? (circle all that apply)

☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Cisgender ☐ Questioning Other _____

Health

Sleep Quality

Y | N	Problems with quality of sleep?		Y | N	Often tired during the day?
	☐ FALLING ASLEEP	☐ MULTIPLE INTERRUPTIONS ☐ EARLY WAKE	Y | N	Snoring?
Y | N	Nightmares?		Y | N	Unusal leg discomfort/movements
Y | N	Fall asleep during day when you want to stay awake?			

Other

Y | N	Any chronic/on-going medical conditions?	Y | N	Any history of head trauma/concussions?

If 'yes' please explain…

Please List All Medications and Who Prescribes Them

Exercise

How do you exercise your body?

Therapist notes :

Client Legal Name: _____ Date of Assessment:_____

Diet/Nutrition			
Describe a typical day of eating:			
Y | N	Do you have problems with your appetite?	Y | N	Do you have stomach or bowel trouble?
Y | N	Do you have food allergies/sensitivities?	Y | N	Are you a picky eater?
Y | N	Do you ever diet?	Y | N	Ever felt like you want to throw-up after eating?
Y | N	Restrict yourself from eating certain foods or follow any rules about your eating?	Y | N	Ever actually done anything to compensate for the food you have eaten? (laxitives, throw-up)
Y | N	Ever felt a loss of control over eating?	Y | N	Is your body the way you would like it to be?

Safety	
Your Safety	
Y | N	In past 3 months, have you hurt yourself purposely but not because you were trying to die?
Y | N	In your lifetime, have you hurt yourself purposely but not because you were trying to die?
Y | N	Have you ever thought about not wanting to be alive any more?
Y | N	Have you ever thought about ending your life?

Have you ever experienced:

Y | N	Physical Abuse	Y | N	Sexual Abuse	Y | N	Emotional Abuse		
Y | N	Domestic Violence	Y | N	Ever Been Threatened?	Y | N	Ever Been Bullied?		

Any other experience of trauma including medical trauma?

Anger Control	
Y | N	Have you ever thought about physically hurting someone.
Y | N	Have you ever threatened to physically hurt someone?
Y | N	Have you ever hit or otherwise hurt someone or an animal?
Y | N	Have you ever been arrested for physically hurting someone or an animal?

Misc			
Y | N	Is your home a safe place?	Y | N	Is your neighborhood a safe place?
Y | N	Is your job/school a safe place	Y | N	Do you experience harassment?
Y | N	Are their any firearms in your home?		
Y | N	If "yes," are the firearms locked securely and ammunition stored separately?		
Y | N	Do you have or have you ever had a fascination with fire/history of setting fires?		

Therapist notes :

Client Legal Name: _____ Date of Assessment:_____

Substance Use						
Nicotine						
Y | N	Do you use nicotine (cigarettes/cigars/chewing tobacco/patch/gum)					
If yes…details: (type, how much, duration)						
Alcohol						
Average # alcoholic drinks on typical drinking day?						
How often do you drink 6/+ alcoholic drinks on one occasion?						
Most recent alcoholic drink?						
Other Drugs						
Y | N	Current experimentation with recreational drugs?					
Y | N	Current over use of prescription meds or taking prescription meds not prescribed to you?					
Y | N	Past experimentation with recreational drugs or prescription medication?					
All Substances						
Y | N	Have people ever said they were concerned about your drinking or other drug use?					
Y | N	Have you ever had guilt/bad feelings about your drinking or other drug use?					
Y | N	Have you ever used alcohol or other drugs first thing in the morning just to steady your nerves?					
Has your drinking or other drug use ever caused clinically significant impairment or distress in the following areas:						
Y | N	Personal Relationships	Y | N	Work	Y | N	Health (blackouts, substance-related medical problems)	
Y | N	Legal (DUI's, arrests)	Y | N	Financial			
Comments/concerns about any of your substance use?						

Past Substance Use Treatment			
Type of Treatment	Provider	Meds	Outcome

Therapist notes :

Client Legal Name: _____ Date of Assessment:_____

Substance Use (continued)

Family Substance Use History

Y	N	Family History of Substance Abuse/Dependence/Addiction?

If yes…who?

Is there anything else about you that I should know but you aren't quite ready to talk about yet?

Multisymptom Checklist

Please Circle Anything That You Feel Are Issues for You

aggression	energy	loneliness	shyness
ambition	family arguments	making decisions	social challenges
anger	fears	marriage	stealing/lying
anxiety	finances	memory	stomach trouble
appetite	friendships	over-dependency	temper tantrums
avoidance	gender identity	over-sensitive	tiredness
career choices	grooming	parenting	under-activity
children	harrassment	physical complaints	excessively defiant/arguementative
concentration	headaches	relaxation	unusual habits
controlling	hearing voices	running away	over-activity/hyperactive
cruelty	impulsive	school problems	difficulty telling imagination from what's real
demanding	inferiority feelings	self-control	feeling less powerful than others
depression	internet/computer	self-critical/guilty	feeling more powerful than others
destructive	jealousy/resentment	separation/divorce	worry you are being watched
easily upset	legal matters	sex problems	work
eating problems	my thoughts	stress	education
nervousness	sexual identity		

Therapist notes :