# 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/Pager ( )

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

Drivers License, or permit # _____ State _____ Age_____

Social Security Number _____-_____-_____ Height_____ Weight _____ Gender ☐ M ☐ F

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 _____

What do you expect from your appointment or treatment today?_____

_____

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

_____

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?_____
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 _____
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 (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 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

List Schools attended since Junior High: Reason for leaving

1. _____
2. _____
3. _____

## ♦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

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 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 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 | | | | |

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: | 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 _____

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:_____

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

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? _____

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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? _____

## ♦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?_____

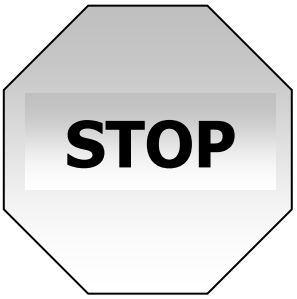
How important to you is it that you change your alcohol/drug use? _____

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

## ♦COUNSELOR SUMMARY (***To be filled out by Counselor***)

| | 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:

_____

_____

Other Misc.: _____

Medical/Dental:

_____

Mental: _____

Motivation Interests: _____

Sports/Clubs Hobbies:_____

Music:_____

**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

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

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Name: _____ Date: _____