**North Oakland Family Counseling Center**
**Consumer Information/Screening**

Name: _____

Address: _____City_____State_____Zip_____

Telephone: Home: _____Work: _____Cell: _____

Occupation: _____Employer_____

S.S. #: _____ Gender: _____ Date of Birth: _____ Age: _____

Race: ☐American Native ☐Asian ☐Black ☐White

Ethnic Background: ☐Arabic ☐Asian ☐East European ☐French ☐German

☐Hispanic ☐Irish ☐Other:_____

Religious Preference: ☐Catholic ☐Christian ☐Jewish ☐Muslim ☐Protestant ☐None Other_____

Does you culture effect your

treatment?_____

_____

Do you presently attend church? _____

Who referred you to us? _____

Person to contact in case of emergency: _____

Relationship: _____Phone#: _____

Physician: _____

Physician Phone Number:_____

Hospital Name and address:_____

Hospital Phone Number:_____

Any Allergies: Yes ☐No If yes, please list_____

Place of Birth_____ Number of Siblings_____

Your place in Family order_____

Father's Education_____Occupation_____

Mother's Education_____Occupation_____

Describe you relationship with your

Father_____

Mother_____

Brother/sisters_____

Did you have child adolescent problems?

_____

_____

With whom did you live with, while growing up? _____

Were you physically or sexually abused as a child? ☐Yes ☐No ☐Unknown

Brother and Sisters:

| **Name** | **Age** | **Sex** | **Biological** | **Step Brother/Sister** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

(if necessary continue on back page)

**Sexual Orientation**: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Transsexual

**Marital Status**:

☐Never Married ☐ Married: Length of time_____

☐Divorced: length of time _____ ☐Divorced in progress

☐Widowed: length of time_____ ☐Re-married; length of time_____

☐Separated: length of time_____ ☐Total number of marriages_____

☐Significant other/Partnership; length of time_____

**First marriage**_____

Age Date Number of children if divorced give date

**Second marriage**_____

Age Date Number of children if divorced give date

**Third marriage**_____

Age Date Number of children if divorced give date

**Children:**

| **Name** | **Age** | **Sex** | **Occupation Or School grade** | **living at home Yes or No** | **Biological or Step** |
|---|---|---|---|---|---|
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**Check items(s), which best describe the relationship with your significant other:**

☐Excellent ☐Good ☐Fair ☐Poor

**Conflicts Over**: ☐Family ☐Mental health problems ☐The children ☐Friends ☐Money

☐Alcohol-drug usage ☐Legal problems ☐Job ☐Other_____

How would you describe your friendships? ☐I have no friends ☐I have only acquaintances

☐I have both acquaintances and close friends

How many close friends do you have? _____

List your leisure/social/recreational activities, including sports, hobbies and intrest:

_____

_____

_____

**Education**:

What is the highest grade/degree you have completed? _____

What is the highest grade/degree your spouse has completed? _____

Additional vocational training (*specify)*_____

**Employment**:

Name of present employer: _____

Job title: _____ Length of time on the job_____

Job duties_____

Please describe how you get along with people at work_____

_____

What jobs have you held in the past?

| **Job** | **Length** | **Reason for leaving** | **Job satisfaction** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

So you currently have financial problems? ☐Yes ☐No

**Military History:**

Have you ever served in the military? ☐Yes ☐No

Branch of service_____ Duty_____ Highest rank_____

Discharge date:_____ Type of discharge:_____

**Legal History:**

**Current Status**:

Are you involved in any cases (traffic, civil, criminal): ☐Yes ☐No

If yes, please describe: _____

Are you presently on probation or parole? ☐Yes ☐No

If yes, please describe: _____

**Past History:** ☐Yes ☐No Traffic Violations (other than parking)

☐Yes ☐No Criminal Involvement

☐Yes ☐No Civil involvement

If yes to any of the above, describe the circumstances:

_____

**Medical History**

Eating/appetite problems ☐Yes ☐No Explain_____

Contagious and/or other diseases ☐Yes ☐No Explain_____

Disability/handicap ☐Yes ☐No Explain_____

Surgery ☐Yes ☐No Explain_____

Accidents ☐Yes ☐No Explain_____

Major Illness ☐Yes ☐No Explain_____

Other_____

Have you ever been hospitalized ☐Yes ☐No

Explain:

_____

_____

Are you currently taking any medication either prescribed by a physician or over the counter? (if yes please list name of medication, frequency of usage, length of time on medication and

dosage)_____

_____

_____

Prior Counseling/Treatment Information:

Have you ever received prior counseling, alcohol/drug abuse, or psychiatric services? (if yes, state when and

where):_____

_____

_____

When did you have your last physical exam_____

How would you describe your general health? ☐Good ☐Fair ☐Poor

Check all of the following physical conditions that apply to you:

☐Thyroid problem ☐Headache ☐Menstrual problems ☐Diabetes mellitus ☐Chest pains

☐Low blood sugar ☐Asthma ☐High blood pressure ☐Trouble sleeping ☐Seizure

☐Chest Pains ☐Stomach ulcers ☐Ulcerative colitis

Other(specify)_____

Do you have, or in the past has any Sleep problems? ☐Yes ☐No

Explain_____

**Check List On The Use Of Alcohol And Other Drugs:**
(Check as many of the following statements that apply)

I frequently (once or twice a day) find that my conversation centers on drugs or drinking experiences. ☐Never ☐Past ☐Now

I drink or take drugs to deal with tension stress. ☐Never ☐Past ☐Now

Most of my friends or acquaintances are people I drink or take drugs with. ☐Never ☐Past ☐Now

I have lost days of work (school) because drinking or using drugs. ☐Never ☐Past ☐Now

I have the shakes when going without drinking or drugs. ☐Never ☐Past ☐Now

I regularly take drugs or drink upon awakening, before eating or while at work (school)☐Never ☐ Past ☐Now

I have been arrested for driving under the influence of alcohol or drugs, or possession of drugs. ☐Never ☐Past ☐Now

I have memory loss when using alcohol or drugs. ☐Never ☐Past ☐Now
Family members think that drinking or other drugs usage is a problem for me. ☐Never ☐Past ☐Now

I have tried to quit using but find that I cannot. ☐Never ☐Past ☐Now

I often double up and/or gulp drinks or drink more then others at parties. ☐Never ☐Past ☐Now

I often drink or take drugs to "get ready" for a social occasion. ☐Never ☐Past ☐Now

I hide alcohol/drugs from family, friends, co-workers and/or supervisors at work so that they will not know that I am using or how much I am using.
☐Never ☐Past ☐Now

I often drink or take drugs by myself. ☐Never ☐Past ☐Now

My drinking or drugs usage has led to conflict with relationships. ☐Never ☐Past ☐Now

## What are your goals for treatment?

1._____
_____
_____

2._____
_____
_____

3._____
_____
_____

Client signature Date

Therapist signature and credentials Date