Client Name: _____ Date: _____

OHP / Medicaid Member Number: _____

ACE (Adverse Childhood Experience) Score:

_____

Has your client ever been diagnosed with a mental illness? Yes No

If so, what is the diagnosis on record? _____

Does your client have a prescription for their mental health condition? Yes No

Is your client currently taking medications for their mental health condition? Yes No

Is your client satisfied with the medication and dosage currently prescribed? Yes No

If not, please explain: _____

_____

Does your client feel like they have adequate access to their medications? Yes No

Suicide Risk Level

Does your client have recent thoughts of harming themselves? Yes No

When was the last time your client had thoughts of harming themselves? _____

Has your client ever attempted to take their own life ever in their lifetime? Yes No

If so, how many times? _____ Date of last attempt: _____

Has your client ever been on a suicide watch? Yes No

Does your client currently have a plan, and a means to follow through with suicide? Yes No

If your client has recent thoughts of harming themselves and/or a plan to commit suicide, please call 988 and connect client with emergency counselor.

Abuse History

Is your client currently fleeing domestic violence? Yes No

Has the client ever been a victim of physical or sexual abuse in their life? Yes No

Was the perpetrator convicted of the crime against your client? Yes No

If not, is your client willing to testify about the alleged abuse? Yes No

If not willing to testify, please explain why: _____

_____

_____

Has your client ever been a victim of mental or emotional abuse in their life? Yes No

Did the client ever receive or still receiving treatment such as counseling or therapy for the trauma they have experienced? Yes No

If not, is your client willing to get connected to a local therapist? Yes No

If not, please explain why: _____

_____

Addiction History

Does the client, or anyone in the client's family have a history of drug and or alcohol abuse in their lifetime? Yes No

Has the client ever been in trouble with the law due to addiction? Yes No

Could the client pass a UA if it was given today (Excluding legal substances)? Yes No

When was the last time the client abused drugs and or alcohol? _____

Has the client ever used drugs via IV in their lifetime? Yes No

If so, date of last time your client used drugs via IV: _____

If the client has used drugs via IV, have they ever been checked for blood borne diseases such as Hepatitis C and AIDS? Yes No

If so, date of last time your client was checked for Hepatitis C and AIDS: _____

Is the client currently suffering from an addiction (both legal and illegal)? Yes No

If so, please list all addictions (including those not drug or alcohol related)

_____

Is the client currently attending meetings and/ or support groups for addiction? Yes No

If the client is not currently attending 12-step meetings and/ or support groups, are they interested in joining and/ or getting information about joining a recovery group? Yes No

Diet / Exercise/ Sleep

How many times a day does your client eat? _____

Does your client experience food cravings? Yes No

If so, what food cravings does your client experience? Please list:

_____

How many 8oz glasses of water does your client drink per day? _____

Does your client drink more than one glass of any of the following? Please circle all that apply.

Coffee Soda Juice Milk Tea Beer Alcohol

How would your client describe their current diet? _____

_____

Is there anything stopping your client from eating healthy foods? If so, please list reasons:

_____

_____

What is your client's idea of a healthy diet? _____

_____

Is your client happy with their current diet? Yes No

If not, is your client interested in getting connected to resources to help with education about a better diet and healthy cooking classes? Yes No

Does your client sleep 6 hours or more every night? Yes No

If not, please explain: _____

_____

How many times per week does your client exercise? Please circle all that apply.

Never 1-2 times 3-4 times 5 or more

Does your client have any physical conditions that prevent them from exercising? Yes No

If so, does your client have a primary care physician? Yes No

If not, is your client interested in getting connected to a local primary care physician? Yes No

Social Interaction & Relationship History

Did your client grow up in a low income or poverty community? Yes No

Did your client ever play sports or participate in any social clubs in school? Yes No

If not, please explain why: _____

_____

Did your client have an I.E.P (Individual Education Plan) in school? Yes No

If so, please explain what the I.E.P was for: _____

Did your client's parents have a good relationship? Yes No

If not, please explain why: _____

_____

If your client had siblings, did they have a good relationship? Yes No N/A

If not, please explain why: _____

_____

Did your client grow up with healthy affection in the home? Yes No

Does your client enjoy giving or receiving hugs? Yes No

Is your client currently in a long-term relationship? Yes No

If not, why did the last long term relationship end? Please explain: _____

_____

Does your client make friends easily? Yes No

If not, why does your client believe they don't make friends? Please explain: _____

_____

_____

Does your client currently have one or more people they identify as a "safe person"? Yes No

Does your client feel like they have a support system? Yes No

If not, why does your client feel like they don't have a support system? Please explain: _____

_____

Does your client feel like they are a good friend? Yes no

If not, why does your client feel like they aren't a good friend. Please explain: _____

_____

Grief & Loss History

Has your client ever experienced the sudden loss of someone they love? Yes No

If so, was it traumatic? Yes No

How long ago was the sudden loss? _____

Is your client able to talk about the sudden unexpected loss without crying? Yes No

If your client is able, please explain their sudden loss: _____

_____

Has your client ever experienced the loss of a parent or sibling? Yes No

Has your client ever experienced the loss of a child (including a miscarriage)? Yes No

Has your client ever experienced the loss of a significant other? Yes No

Has your client ever experienced the loss of a close relative or friend? Yes No

Has your client ever experienced the loss of a close pet? Yes No

If your client has answered yes to any of the situations above, did your client receive or is still receiving grief counseling? Yes No

If not, is your client interested in getting resources for local grief counseling and support groups? Yes No

Has your client experienced the sudden loss of a job, an opportunity that they were counting on or housing? Yes No

Does your client feel like they were wronged with the loss of job, opportunity, or housing? Yes No

If so, have your client explain why they felt like they were wronged: _____

_____

Does your client feel like they played a part in the sudden loss of job, opportunity, or housing? Yes No

In the future, what does your client feel like they need to do differently to avoid a future loss of job, opportunity, or housing? Please explain: _____

_____

_____

The Senses & Expression

What is your client's favorite smell? _____

Please have your client explain why it's their favorite smell: _____

_____

What is your client's favorite food? _____

Please have your client explain why it's their favorite food: _____

_____

How does black make your client feel? Circle one: Happy Sad Mad Nothing

What's the first thing that comes to your client's mind when you say black? _____

How does red make your client feel? Circle one: Happy Sad Mad Nothing

What's the first thing that comes to your client's mind when you say red? _____

How does green make your client feel? Circle one: Happy Sad Mad Nothing

What's the first thing that comes to your client's mind when you say green? _____

How does blue make your client feel? Circle one: Happy Sad Mad Nothing

What's the first thing that comes to your client's mind when you say blue? _____

How does yellow make your client feel? Happy Sad Mad Nothing

What's the first thing that comes to your client's mind when you say yellow? _____

What is your client's favorite material or texture to touch? _____

Please have your client explain why it's their favorite material or texture to touch: _____

_____

What is your client's favorite genre of music? _____

Please have your client explain what they feel when they listen to the music they like: _____

_____

Does your client currently have access to or play a musical instrument? Yes No

If so, have your client explain what they feel when they are playing an instrument: _____

_____

If your client doesn't have access to a musical instrument, is your client interested in learning about opportunities to play a musical instrument? Yes No

Does your client enjoy artistic activities such as drawing, painting, scrapbooking, or coloring? Yes No

If so, what is your client's favorite art activity? _____

Have your client explain what they feel when they are doing their favorite art activity: _____

_____

Does your client currently have access to art supplies? Yes No

If not, is your client interested in getting art supplies to take home? Yes No

Does your client enjoy a good laugh? Yes No

If so, how does your client feel when they are laughing? _____

_____

Have your client think of the top three things they find funny, and list them below.

_____ _____ _____

Have your client explain why they find those things funny: _____

_____

Have your client think of the top three things they find beautiful, and list them below.

_____ _____ _____

Have your client explain why they find those things beautiful: _____

_____

Does your client believe in or pray to a higher power? Yes No

Does your client practice religion? Yes No

If your client practices religion, are they currently attending church? Yes No

Does your client currently feel spiritually fulfilled? Yes No

Have your client define spirituality in their own words: _____

_____

What does peace look like to your client? _____

_____

Notes / IGP (Individual Goal Plan)

Brief Summary: _____

_____

_____

_____

_____

Negative Factors: _____

_____

_____

Positive Factors: _____

_____

_____

Programs that your client would benefit from: Circle all that apply.

Nature Therapy	**Expression Therapy**	**Self Help Work Sessions**	**Social Activities**
Beach Walks	Playing music	One on one	Beach Clean-ups
Forest Walks	Doing Art	Support Groups	Volunteering
Hiking Trips	Journaling	Grief Support	Movie nights

Extra Notes: