[**FORM 30**—Use the top of this page for your letterhead.]

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

(cont.)

FORM 30. Adult checklist of concerns (p. 1 of 2). From *The Paper Office*. Copyright 2008 by Edward L. Zuckerman. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns . . . ")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

- ❑ _____
- ❑ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

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[FORM 26—Use the top of this page for your letterhead.]

Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, supplements, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

(cont.)

FORM 26. Brief health information form (p. 1 of 3). From *The Paper Office*. Copyright 2008 by Edward L. Zuckerman. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____

(cont.)

3. Do you try to restrict your eating in any way? How? Why? _____

_____

_____

4. Do you have any problems getting enough sleep? _____

_____

_____

E. For women only

1. At what age did you start to menstruate (get your period): _____
2. Menstrual period experiences:
   a. How regular are they? _____
   b. How long do they last? _____
   c. How much pain do you have? _____
   d. How heavy are your periods? _____
   e. Other experiences during period? _____
3. Please list all of your pregnancies:

	What happened with this pregnancy?			
Your age	Miscarriage	Abortion	Child born	Problems?
1.				
2.				
3.				
4.				
5.				
6.				

4. Menopause:
   a. If your menopause has started, at what age did it start? _____
   b. What signs or symptoms have you had? _____

_____

F. Other

Do you use tobacco? ❑ Yes ❑ No If yes, how many cigarettes/cigars/other (circle all that apply) per day?: _____

Have you ever injected drugs? ❑ Yes ❑ No Ever shared needles? ❑ Yes ❑ No

Have you had HIV testing in the last 6 months? ❑ Yes ❑ No If yes, results: _____

Are there any other medical or physical problems you are concerned about? _____

_____

_____

_____

Note: Significant aspects of family medical history should be recorded on "Client Information Form 2."

[**FORM 27**—Use the top of this page for your letterhead.]

Chemical Use Survey

Name: _____ Date: _____

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and/or other chemicals that can affect you psychologically. So please answer these questions fully.

A. What have you used?

1. Think about any and all chemicals you have used, and indicate how much you used (amount) and how often. Then indicate all the effects it had on you (mental, physical, family, legal, etc.).

Chemical	Age started	Last use	Over the last 30 days		See question 3, below
			Amount and how often	Effects/consequences	
Caffeine					
Tobacco (smoked or chewed)					
Alcohol					
Marijuana/THC					
Cocaine/crack (snorted, injected, or smoked)					
Inhalants ("Huffing")					
LSD					
Prescribed pills					
Others: Specify					

2. Write "P" above next to your primary drug of choice.
3. For each chemical you currently use, what causes you to stop? Enter one or more of these letters in the last column above: A = The money runs out. B = I use up my supply. C = Personal choice. D = Unconsciousness. E = Achieved my purpose. F = Other reasons: _____
4. What are or were your sources of money for buying the chemicals you have used? _____

_____

B. Which of these have you had? ❑ Blackouts ❑ Withdrawal symptoms ❑ Cravings ❑ Overdoses

❑ Detoxification in a hospital ❑ Tolerance ("Could not get high no matter how much I took")

❑ Preoccupation (spent lots of time finding and using chemicals) ❑ Failed attempts to cut down or control use

❑ Other problems: _____

(cont.)

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C. Family patterns of chemical use

Please describe the chemical(s) used by family members.

	Name	Chemical	Age started	Last use	Over the last 30 days: Amount and how often	Over the last 30 days: Effects
Father						
Mother						
Brothers/ sisters						
Spouse/ partner						
Other relatives						

Please add any other information you think is important: _____

D. Treatment for chemical use

Dates: From	Dates: To	Agency/provider	Type of program*	Voluntary? (Yes or no)	Length of treatment	Methods used	Participation in aftercare programs (No/Which?)	Effects of treatment†

*In the fourth column, use these codes: AA/NA = Alcoholics Anonymous/Narcotics Anonymous; O = Outpatient counseling; ID = Inpatient detoxification; IT = Inpatient treatment (e.g., 28-day); O = Other.

†In the last column, use these codes: W = made situation Worse; N = No change; U = better Understanding of addiction; R = Reduction of use; BA = Brief abstinence (up to a month); LA = Long-term abstinence (several months or more); O = Other effects

F. Self-description of use

1. Would you say you ❑ are a social drinker? ❑ are a heavy drinker? ❑ have alcoholism? ❑ have a drinking problem? Or how would you describe your use? _____

2. Would you say you ❑ are a recreational drug user? ❑ have a drug problem? ❑ have an addiction? Or how would you describe your use? _____

G. Other

Has your drinking/drug use caused you any spiritual problems? _____

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Patient Name_____ Patient DOB_____

PSYCHATRIC HISTORY

[ ] [ ] Prior outpatient psychotherapy?
Yes No If yes, on _____ occasions. Longest treatment by _____ for _____sessions from _____ to _____

Provider Name	Phone Number	Diagnosis	Beneficial?

[ ] [ ] Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?
Yes No If yes, on _____ occasions. Longest treatment at _____ from_____ to _____

Name of Facility	Phone Number	Diagnosis	Beneficial?

[ ] [ ] Current psychotropic medication usage? If yes,
Yes No

Medication	Physician	Phone Number	Beneficial?

Annual Gross Income
[ ] 0 – 24,999
[ ] 25,000 – 49,999
[ ] 50,000 – 74,999
[ ] 75,000 – 99,9999
[ ] 100,000 – 149, 999
[ ] 150,000+

Financial Situation
[ ] No current financial problems
[ ] Large indebtedness
[ ] Poverty or below- poverty income
[ ] Impulsive spending
[ ] Relationship conflicts over finances

Current physical health [ ] Good [ ] Fair [ ] Poor

[ ] Asthma/COPD	[ ] Chronic Pain
[ ] Cancer	[ ] Dementia
[ ] Diabetes	[ ] Obesity
[ ] Cardiovascular Problems	[ ] High Blood Pressure

Other:

Legal History
[ ] No legal problems
[ ] Now on parole/probation
[ ] Arrest(s) substance related
[ ] Arrest(s) non-substance related
[ ] Jail/Prison_____time(s)