Comprehensive

Behavioral Health

Self-Evaluation

This evaluation is designed to help you understand your life challenges more clearly, and to help me better know how to help you. It is comprehensive in that it evaluates many domains of your life, and because of that, it may take you up to an hour (sometimes longer) to complete. There is ***no need to do it all in one sitting***, so feel free to take breaks if you want.

When you see "**instructions**" please take the time to read them, and most important, pay attention to the ***time frame*** specific to the questions being asked (e.g., last 7 days, last two weeks, last 6 months).

And please answer all questions as accurately and honestly as possible. If you have a problem with a question, feel free to skip it and bring it up with me in session. Remember, all your answers are confidential and covered by our confidentiality agreement.

Thanks for taking the time to do this.

Name: _____

Date of Birth: _____ Age: _____

Date: _____

Presenting Problem

Why are you seeking counseling help? _____

_____

_____

_____

Education

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

University / College / Trade School / Other:_____ (circle all that apply)

Degree(s)_____ What field(s)?_____

Currently enrolled in school? Yes ❑ No ❑ if yes, where?_____

Past/Present problems in school? Yes ❑ No ❑ (if yes, circle all that apply) failing grades / suspensions school changes / reading / writing / math / understanding the teacher / cooperating with other students

How do you learn best?

❑ Visual – learn through reading, seeing things, graphics, illustrations

❑ Auditory – learn by hearing information, listening to tapes, music

❑ Tactile – learn by touching things, feeling in the body, movement

Employment/Financial Situation

Employed? Yes ❑ No ❑ if yes, where?_____

How long?_____ Job title or duties:_____

If not employed, please explain (include being disabled):_____

_____

Have you had trouble keeping jobs? Yes ❑ No ❑ if yes, why do you think so?_____

_____

Trouble with current job (circle all that apply): absenteeism / tardiness / boredom / decrease in performance arguments with other employees / not challenged / burned-out / stress / sexual harassment / other:_____

_____

Has your income changed a lot during the past two years? Yes ❑ No ❑ How? Gone up / Gone down

Do you have any financial difficulties? Yes ❑ No ❑ if yes, please explain:_____

_____

Legal

Have you ever been arrested? Yes ❑ No ❑ if yes, how many times?_____ if no, go to next section

Number of arrests in the last two years?_____ Charges:_____

Total number of DUII's:_____ Total DUII's in the last 5 years:_____ Date of last one:_____

How many days/months have you spent in jail or prison in your lifetime:_____

What have you been arrested for (circle all that apply): alcohol & drug offenses / crimes against people domestic violence / sex crimes / restraining order / crimes against property (burglary/theft) / Other (list):

_____

Are you currently involved in the legal system? Yes ❑ No ❑ if yes, what is your status?_____

_____

Are you mandated to be in treatment? Yes ❑ No ❑ if yes, by who?_____

Spiritual

My family's religious denomination preference was / is:_____

My current religious denomination preference was / is:_____

My current religious or spiritual practices include (prayer, church, meditation, etc.):_____

_____

Do you believe spiritual/religious issues relate to your current problems? Yes ❑ No ❑ if yes, explain:_____

_____

Sexual

My sexual orientation/gender is: Male ❑ Female ❑

How do you label yourself (circle): Heterosexual / Bisexual / Homosexual / Asexual / Don't know

I am presently in a one-person relationship? Yes ❑ No ❑ if yes, how long?_____

Sexually active? Yes ❑ No ❑ Never ❑

If yes, how many partners in the past six months (circle): 1 2 3 4 5 +

Any current problems with sex that should be addressed in treatment?_____

_____

Military

Military Service? Yes ❑ No ❑ if yes, are you currently serving? Yes ❑ No ❑

Branch:_____ Discharged: Honorable / General / Medical / Dishonorable (circle one)

Dates served:_____ I had problems in the military related to addiction: Yes ❑ No ❑

I have participated in combat zone military actions: Yes ❑ No ❑ if yes, please describe:_____

_____

Physical/Medical Health

I would rate my <u>overall physical health</u> as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

Name of Primary Care Physician_____ Date of last visit_____

Do you see any other doctors? Yes ❑ No ❑ if yes, who and for what?_____

_____

List all <u>current</u> medications	**Dosages**	**Reason for medication**

How many times, when, and for what have you been hospitalized for medical problems in the last 5 years?

_____

_____

_____

_____

Do you exercise? Yes ❑ No ❑ if yes, how many days per week: 1 2 3 4 5 6 7

What do you do?_____

Have you ever injected any substance into your body? Yes ❑ No ❑ if yes, what?_____

Have you ever had unprotected sex that may have put you at risk for infectious diseases? Yes ❑ No ❑

Do you own any guns? Yes ❑ No ❑ if yes, are they secured from children? Yes ❑ No ❑

Do you have, or have you ever had: (circle those that apply and write in others)		
Eye, ear, nose, throat problems: glaucoma; lens implants; dentures, loose teeth, dental caps or bridges; wear hearing aids, glasses, contacts or artificial eye	Yes	No
Heart problems: chest pain, angina, heart attack, congestive heart failure, irregular heartbeats, pace maker, defibrillator	Yes	No
Vascular problems: high blood pressure, blood cots	Yes	No
Lung problems: asthma, emphysema, tuberculosis, coughing, coughing blood, sleep apnea	Yes	No
Gastrointestinal problems: hepatitis, cirrhosis, ulcers, hiatal hernia, intestinal bleeding, vomiting/diarrhea within the last 24 hours	Yes	No
Genitourinary problems: OB/GYN, kidney disease/failure, prostate problems, incontinence, sexually transmitted diseases, infections	Yes	No
Musculoskeletal problems: back problems, broken bones of neck/back/face, limited range of motion, arthritis, TMJ	Yes	No
Skin problems: rash, hives, bruise easily, open sores	Yes	No
Neurological problems: seizures, paralysis/numb areas, stroke, weakness, migraines, confusion	Yes	No
Endocrine problems: diabetes, thyroid	Yes	No
Cancer:	Yes	No
Head injury:	Yes	No
Possibility you could be pregnant? Approximate due date?	Yes	No
Allergies To what?	Yes	No

Mental Health

Instructions: Over the **last SEVEN (7) DAYS**, how often have you been bothered by any of the following problems. Circle the number that best describes the frequency of the problem.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have notice? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total Score =				

Instructions: **Prior to your 18th birthday**, did any of the following things happen to you? Check yes or no.

	Yes	No
1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? Or Attempt or actually have oral, anal, or vaginal intercourse with you?		
4. Did you often or very often feel that… No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you often or very often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were your parents ever separated or divorced?		
7. Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, get kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes, or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? Or that had a behavioral addiction that you knew of like gambling or acting out sexually?		
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?		
10. Did a household member go to prison?		
Total Score =		

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	None Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4
Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4
Feeling that your illnesses are not being taken seriously?	0	1	2	3	4
Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
Difficult getting to sleep, staying asleep, or not getting enough sleep?	0	1	2	3	4
Excessive sleepiness or fatigue during the day?	0	1	2	3	4
Known restless leg syndrome, or aching or sore legs upon waking in the morning?	0	1	2	3	4
Do you experience frequent urination at night?	0	1	2	3	4
Do you know if you snore, or experience gasping or choking sounds while you are asleep?	0	1	2	3	4
Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4
Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
Feeling driven to perform certain behaviors or mental acts over and over again?	0	1		3	4
Have you ever used laxatives or diuretics to control your weight?	0	1	2	3	4
Have you ever made yourself throw-up or starved yourself because you thought you were fat?	0	1	2	3	4
Have you ever lost so much weight that others worried about you?	0	1	2	3	4
Have you ever felt fat when others told you that you were thin?	0	1	2	3	4

Instructions: Over the **last SEVEN (7) DAYS**, how often have you been bothered by any of the following problems. Circle the number that best describes the frequency of the problem.

	Never	Rarely	Sometimes	Often	Always
1. I felt fearful.	1	2	3	4	5
2. I felt anxious.	1	2	3	4	5
3. I felt worried.	1	2	3	4	5
4. I found it hard to focus on anything other than my anxiety.	1	2	3	4	5
5. I felt nervous.	1	2	3	4	5
6. I felt uneasy.	1	2	3	4	5
7. I felt tense.	1	2	3	4	5
Total Score =					

Have you ever been hospitalized for a mental health or psychological problem? Yes ❑ No ❑

If yes, how many times?_____ Why were you hospitalized? _____

_____

_____

_____

Have you ever used psychiatric medications to address a mental health problem? Yes ❑ No ❑

If yes, are you regularly taking a psychiatric medication(s) right now? Yes ❑ No ❑

If yes, what psychiatric medications are you taking right now:

Medication	Reason for Taking

Instructions: Check the box that best describes how you have felt and conducted yourself **over the past 6 months**.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	❑	❑	❑	❑	❑
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	❑	❑	❑	❑	❑
3. How often do you have problems remembering appointments or obligations?	❑	❑	❑	❑	❑
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	❑	❑	❑	❑	❑
5. How often to do you fidget or squirm with your hands or feet when you have to sit down for a long time?	❑	❑	❑	❑	❑
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	❑	❑	❑	❑	❑

For the following questions, please consider your early childhood life (age 5 to 15). For each parent, or the two most involved caregivers in your life, please rate on a scale from **1 (least)** to **7 (most)** how well each of them did on the following Parenting Factors. Note that higher scores mean your parent (or caregiver) was ***consistent and reliable*** on each of the factors.

Parenting Factors	**Mother or Caregiver #1**	**Father or Caregiver #2**
(1) Felt Safety/Protection Kept me safe from danger and threats	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(2) Feeling Seen and Known (Attunement) Was emotionally in tune with how I was feeling, could read my emotions and respond in a way that made me feel they understood how I felt	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(3) Felt Comfort/Soothing and Reassurance Calmed and soothed me effectively when I became upset or overwhelmed	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(4) Feeling Valued/Expressed Delight Made me feel special, took interest in me, made me feel valued, I was twinkle in their eye	1 2 3 4 5 6 7	1 2 3 4 5 6 7
(5) Felt Support for Best Self/Self-Development Helped me express my natural talents, supported me becoming the best version of myself possible, encouraged self-exploration	1 2 3 4 5 6 7	1 2 3 4 5 6 7

Choose five adjectives or words that **reflect your relationship with your mother and father (or the two most involved caregivers in your life)** starting from as far back as you can remember in early childhood – as early as you can go (between ages of 5 and 15 is fine).

Mother (Caregiver #1)	**Father (Caregiver #2)**
1.	1.
2.	2.
3.	3.
4	4.
5.	5.

To which parent (or caregiver) did you feel the closest? _____

Why?

_____

_____

_____

_____

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each type of event listed, please **check yes** if the event: 1) happened to you personally, 2) you witnessed it, or 3) if you are not sure if it fits, but it might. Please consider your entire life as you go through the list. Then, on a scale from **1 (least impact)** to **7 (greatest impact),** circle the number that best represents the degree to which you feel the type of event has impacted your entire life.

Type of Event	Yes	1= least impact						7= highest impact
1. Sexual Abuse or Assault: Actual or attempted sexual contact, exposure to age-inappropriate material, sexual exploitation, unwanted/coercive sexual acts	❑	1	2	3	4	5	6	7
2. Physical Abuse or Assault: Actual or attempted infliction of physical pain with or without an object or weapon, use of severe corporeal punishment	❑	1	2	3	4	5	6	7
3. Emotional Abuse/Psychological Maltreatment: Includes verbal abuse, emotional abuse, excessive demands on child's performance, intentional social deprivation	❑	1	2	3	4	5	6	7
4. Neglect: Failure by parents/caregivers to provide needed, age-appropriate care although financially able to do so, includes: physical, medical, educational neglect	❑	1	2	3	4	5	6	7
5. Serious Accident or Illness/Medical Trauma: Unintentional injury or accident, having a physical illness or medical procedures that are painful and/or life threatening	❑	1	2	3	4	5	6	7
6. Witnessing/Experiencing Domestic Violence: Actual or threatened physical or sexual violence, or emotional abuse between adults in intimate relationships – current or former	❑	1	2	3	4	5	6	7
7. Victim/Witness to Community Violence: Violence from people *not in your family*, brutal acts like shootings, stabbings, being robbed, raped or beaten	❑	1	2	3	4	5	6	7
8. School Violence: Includes fatal and nonfatal student or teacher victimization, threats to or injury of students, fights, or exposure to weapon on school grounds	❑	1	2	3	4	5	6	7
9. Natural or Manmade Disasters: Major accident or disaster that is an unintentional result of a manmade or natural event: hurricane, earthquake, flood, fire	❑	1	2	3	4	5	6	7
10. Forced Displacement: Forced relocation to a new home due to political reasons, including political asylees or immigrants fleeing political persecution	❑	1	2	3	4	5	6	7
11. War/Terrorism/Political Violence: Exposure to war, terrorism, political violence, includes incidents like bombing, shooting, looting, or accidents due to terrorist activity	❑	1	2	3	4	5	6	7
12. Victim/Witness to Extreme Personal/Interpersonal Violence: Includes extreme violence by or between individuals including exposure to homicide, suicide and/or other extreme events	❑	1	2	3	4	5	6	7
13. Traumatic Grief/Separation: Death of parent, primary caretaker, sibling, abrupt and/or unexpected, accidental or premature death or homicide of a close friend, family member or relative, indefinite separation from loved one	❑	1	2	3	4	5	6	7
14. System-Induced Trauma: Traumatic removal from the home, traumatic foster placement, sibling separation, or multiple placements in a short amount of time	❑	1	2	3	4	5	6	7

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there relieving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stress experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling asleep or staying asleep?	0	1	2	3	4

Substance Use History

Have you ever used these drugs? (**check all that apply**)		Age of first use	Date of last use (can estimate)	Longest sobriety in the last 30 days (in days)	Longest sobriety in the last 10 years
Alcohol	❑				
Tobacco/Nicotine	❑				
Marijuana/Hashish	❑				
Heroin	❑				
Methamphetamine	❑				
Cocaine	❑				

Prescription Drugs					
Hydrocodone (Vicodin)	❑				
Oxycodone (Percocet)	❑				
OxyContin	❑				
Methadone	❑				
Fentanyl	❑				
Hydromorphone	❑				
Xanax	❑				
Valium	❑				
Ritalin	❑				
Adderall	❑				
Amphetamine - other	❑				
Cough medicine	❑				
Other Rx Drugs:	❑				

Other Drugs					
Bath Salts	❑				
Club Drugs (GHB, Rohypnol)	❑				
E-Cigarettes	❑				
Hallucinogens (LSD, peyote, Salvia)	❑				
Inhalants (Gas, glue, rush)	❑				
Synthetic Cannabinoids (K2/Spice)	❑				
MDMA (Ecstasy/Molly)	❑				
Steroids (Anabolic)	❑				
Other - Please List:	❑				

List all substances used in the **last year**	Average days per month you use substance	Average quantity per day (drinks, grams, # of pills, etc.)	How do you get it into your body? (drink/smoke/IV)
1.			
2.			
3.			
4.			
5.			
6.			

Note: Include pain medication, over the counter drugs, or any other prescription medication if used in any way other than prescribed.

Have you ever had an alcohol-related *seizure*? Yes ❑ No ❑ Estimate of how many? _____

Have you ever experienced *delirium tremens* (DTs)? Yes ❑ No ❑ Estimate of how many? _____

Have you ever experienced *blackouts due to drinking*? Yes ❑ No ❑ Estimate of how many? _____

Instructions: Like substances, we know that behaviors can also become very compulsive or addictive for people. For each of the behaviors listed below, circle the number that best represents how much of a problem (e.g., compulsive, addictive, obsessive) each behavior has been for you **during your lifetime**.

Behavior	**Examples**	**1 = no problem** **10 = big problem**
Eating	Eating to deal with negative moods, eating more than intended, addicted to sugar foods	1 2 3 4 5 6 7 8 9 10
Sex	Compulsive masturbation, pornography, adult social media sites, prostitution, voyeurism, bookstores	1 2 3 4 5 6 7 8 9 10
Gambling	Compulsive video poker, scratch-offs, chasing losses, horse races, online betting	1 2 3 4 5 6 7 8 9 10
Spending	High debts, spending to deal with negative moods, excessive shopping, buying stuff you don't need	1 2 3 4 5 6 7 8 9 10
Internet/ Screen Time	Video gaming, social media sites, chat rooms, constantly checking email, voicemail, hours watching shows, excessive internet surfing	1 2 3 4 5 6 7 8 9 10
Exercise	Excessive exercise, time at gym, obsessed with body	1 2 3 4 5 6 7 8 9 10
Other	Please write in:	1 2 3 4 5 6 7 8 9 10

Have you ever been prescribed a **medication to treat addiction**? Yes ❑ No ❑ What?_____

_____

Treatment History

Have you ever seen a **PRIVATE PRACTICE** psychologist, psychiatrist, counselor, social worker, or other behavioral health professional for any mental health or addiction problems any time in the past? Yes ❑ No ❑
How many professional clinicians have you seen (estimate if needed)? _____
If yes, please list details:

Name of person, or type of clinician you saw	**Year started**	**How Long**	**For problems related to:**
Example: psychologist	*2006*	*1.5 years*	*depression*

Are you **CURRENTLY** seeing any clinicians for mental health or addiction problems? Yes ❑ No ❑
If yes, who are you seeing? _____ How long? _____

Have you ever been to a **TREATMENT PROGRAM** (e.g. residential, intensive outpatient, outpatient) for any mental health or addiction problems any time in the past? Yes ❑ No ❑
How many independent (different) times did you attend a treatment program? _____
If yes, please list details of last five episodes:

Name of treatment program	**Year started**	**How Long**	**For problems related to:**	**Did you complete**
Kaiser Alcohol & Drug	*2009*	*3 months*	*DUII – alcohol problems*	*Yes*

Have you been to **detoxification centers (including hospitals)** for use of alcohol or drugs? Yes ❑ No ❑

If yes, how many times?_____ When was last time you detoxed? _____

Do you – or have you ever - participated in any **self-help groups** (e.g., 12-step, SMART, grief) for mental health or addiction problems? Yes ❑ No ❑
If yes, what programs?_____
_____
_____
_____
How helpful have they been?_____
_____

Family of Origin

For the following section, please list all members of your **family of origin**, including step-parents, foster parents, step-siblings, or extended relatives if they **played a primary role in your life growing-up**.

Family Member Name	Relation	Alcohol, drugs or other addictions?	Mental health problems
Example: David Smith	*Father*	*alcohol and gambling*	*depression*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Family - Current

I am: single / married / separated / divorced / widowed / in a committed relationship (please circle one)
How long?_____ If married, married to 1st / 2nd / 3rd / 4th spouse (please circle one)
Is your spouse/partner employed? : Yes ❑ No ❑ if yes, where:_____

Names of biological children	Age	Any problems or issues? (substance abuse, mental health)
Names of step-children	Age	Any problems or issues?

Social – Living Environment

I currently live in: house / apartment / trailer / rent room / mission / car / street / Other_____

How long?_____(years/months) With whom do you live?_____

_____

Are you satisfied with current living situation: Yes ❑ No ❑ if no, explain:_____

_____

Number of times I have moved in the last five years:_____ Were moves related to current Problems:_____

Number of close friends I have:_____ Number of friends I see in person at least once per week:_____

Who provides you the most emotional support?_____

For support, who do you turn to (circle all that apply): spouse or significant other / family / friends / self-help groups / church / employer / spirituality or religion /
Other:_____

What do you do for fun?_____

_____

END OF EVALUATION

Thank you!

[Shared by John Fitzgerald, PhD, LPC, CAS as part of his Northwest ATTC webinar, February 2019. Find slides/recording/handouts here: https://attcnetwork.org/northwest-webinars]