RESTORATION THERAPY CENTER OF SD

www.HealingHopeFreedom.com

Please read, fill in, and where appropriate, sign and bring all completed forms to your first appointment.

Date: _____ **Referred by:** _____

Personal Information

Name: _____ **Date of Birth:** _____

Home Address: _____
(house number, street, apt. number; city, state, zip code)

Phone: _____ **Email:** _____

Ethnic Identity
(in compliance with CDE)

□ Hispanic / Latino
□ Not Hispanic / Latino

Racial Identity

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or other Pacific Islander
□ White
□ Other *(please identify)*: _____

Gender: _____

Marital Status

□ Single □ Married □ Domestic partnership □ Separated □ Divorced □ Widowed

Children	*Child #1*	*Child #2*	*Child #3*	*Child #4*
Name				
Sex				
Age				
Grade				

Highest level of education completed □ Less than High school diploma □ High school diploma

□ Associate's degree □ Bachelor's degree □ Master's degree □ Doctoral degree □ Other: _____

Occupation: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Presenting Problem & Motivation

Describe your goals / reasons for seeking therapy: _____

_____

What effect has this issue or concern had on your family, ability to work, or daily activities? _____

_____

How long have you been dealing with the issue(s)? _____

What have you done to deal with this issue or concern up to this point? _____

_____

Current level of motivation to change/work on the problem:

(not at all) □ *1* □ *2* □ *3* □ *4* □ *5* *(very much)*

Please describe attributes or characteristics that you view as personal strengths: _____

_____

Is there anything else you would like your therapist to understand regarding you and your goals: _____

_____

Have you ever seen a counselor / therapist before? □ yes / □ no

Physical, Mental, & Spiritual Assessment

PART 1: Physical Assessment

Please describe your physical health today *(e.g., jet-lagged; distracted; recovering from illness; hungover)*: _____

_____

Any concern that might hinder our work *(e.g., hearing problems)*: _____

Please state any current medical diagnosis, including prescribed medication *(name, dosage, frequency)*: _____

_____

_____

Please list any additional relevant medical history: _____

PART 2: Mental Assessment

Have you recently thought of harming yourself or hurting someone else? □ yes / □ no

If yes, please explain: _____

Please state any current psychiatric diagnosis you have received: _____

_____

Have you ever taken medications for emotional / psychiatric problems? □ yes / □ no

Use extra space if needed.

Name of Medication	Reason for subscription	Dosage	Frequency	How long did you / have you been taking it?

Have you ever been hospitalized for psychiatric reasons? □ yes / □ no

If yes, please explain: _____

Name & contact info of psychiatrist: _____

PART 3: Spiritual Assessment

Religious Affiliation: _____

How central is your faith to your day-to-day life? *(not at all)* □ *1* □ *2* □ *3* □ *4* □ *5* *(very)*

Would you like your faith to be incorporated in our work: □ yes / □ no

Family Background

Where were you born? _____ Where did you grow up? _____

Number of moves during childhood: _____

Have you ever been placed in: □ Kinship care □ Group home □ Foster family □ Adoptive family? □ N/A

Biological mother

Name: _____ Age: _____ Occupation: _____

If deceased, her age at time of death: _____ How old were you? _____

Cause of death: _____

How would you describe your relationship with her? _____

Biological father

Name: _____ Age: _____ Occupation: _____

If deceased, his age at time of death: _____ How old were you? _____

Cause of death: _____

How would you describe your relationship with him? _____

Are your biological parents married? □ yes / □ no *If no, please explain:* _____

Who else helped to raise you *(e.g., grandparents, foster family, adoptive family)*?

Guardian #1

Name: _____ Age: _____ Occupation: _____

How would you describe your relationship with him/her? _____

When did you live with him/her? _____

Guardian #2

Name: _____ Age: _____ Occupation: _____

How would you describe your relationship with him/her? _____

When did you live with him/her? _____

Primarily language used in your family of origin: □ English □ Spanish □ Other: _____

How would you describe your family life? _____

_____

How was love expressed in your home? _____

How was anger handled in your home? _____

Were you disciplined / punished as a child? □ yes / □ no

If yes, please describe how: _____

During your childhood, were there any serious illnesses, accidents, or death in your immediate family?

□ yes / □ no *If yes, please specify:* _____

At what age did you leave home? _____ □ I still live with my parents

Why did you leave home? _____

Siblings

Please list your sibling in birth order:

Name	Type *(full, half, step, adoptive)*	Gender	Age	Describe your relationship
1)				
2)				
3)				
4)				
5)				

How would you describe your relationship with your siblings in general? _____

_____

Has anyone in your family ever been diagnosed with a mental disorder / psychiatric problem? □ yes / □ no

If yes, please specify (name, relationship, diagnosis): _____

_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

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**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**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	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Relationship Assessment

Name and age of spouse / romantic partner: _____

Beginning date of relationship: _____ Length of relationship: _____

What initially attracted you to your partner: _____

Areas of compatibility: _____

When was the relationship most satisfying, and why? _____

Relationship Assessment Scale (RAS)[*]

Please mark the letter for each item which best answers that question for you.

1. How well does your partner meet your needs?

A	B	C	D	E
Poorly		*Average*		*Extremely well*

2. In general, how satisfied are you with your relationship?

A	B	C	D	E
Unsatisfied		*Average*		*Extremely satisfied*

3. How good is your relationship compared to most?

A	B	C	D	E
Poor		*Average*		*Excellent*

4. How often do you wish you hadn't gotten in this relationship?

A	B	C	D	E
Never		*Average*		*Very often*

5. To what extent has your relationship met your original expectations:

A	B	C	D	E
Hardly at all		*Average*		*Completely*

6. How much do you love your partner?

A	B	C	D	E
Not much		*Average*		*Very much*

7. How many problems are there in your relationship?

A	B	C	D	E
Very few		*Average*		*Very many*

FOR OFFICE USE ONLY
Rating: A=1, B=2, C=3, D=4, E=5
Add up the items and divide by 7 to get a mean score.
Note: Items 4 and 7 are reverse scored.
MEAN SCORE: _____

Areas of tension: _____

How do the two of you express and deal with frustrations and anger with each other? _____

_____

[*]*RAS adapted from: Dicke, A., & Hendrick, C. (1998). The relationship assessment scale. Journal of Social and Personal Relationships, 15, 137-142.*