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: _____

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

Date: _____ **Referred by:** _____

Personal Information — Minor

MINOR

Name: _____

Date of Birth: _____ **Gender:** _____

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

Phone: _____ **Email:** _____

Ethnic Identity
(in compliance with CDE)

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino

Adopted: ☐ yes / ☐ no

Racial Identity

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

Emergency Contact

Name: _____ Phone Number: _____ 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

Physical, Mental, & Spiritual Assessment — Minor

PART 1: Physical Assessment

Please describe your general physical health: _____

_____

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

PART 2: Mental Assessment

Have you recently thought of harming yourself or hurting someone else?

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

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

Physical, Mental, & Spiritual Assessment — Parent/Guardian

PART 1: Physical Assessment

Please describe your child's general physical health: _____

_____

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

Please state any current medical diagnosis of your child, including medication *(name, dosage, frequency)*:

_____

_____

Please list any additional relevant medical history: _____

PART 2: Mental Assessment

To the best of your knowledge, has your child recently thought of harming themself or hurting someone else?

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

Please state any current psychiatric diagnosis your child has received: _____

_____

Has your child 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 they been taking it?

Has your child 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 faith to your child's day-to-day life? *(not at all)* □ *1* □ *2* □ *3* □ *4* □ *5* *(very)*

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	

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Child Age 11-17

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

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…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes			☐ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes			☐ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes			☐ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes			☐ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes			☐ No		
	25.	Have you EVER tried to kill yourself?	☐ Yes			☐ No		

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure — Child Age 6-17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			