RESTORATION THERAPY CENTER OF SD

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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	

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