Pre-Assessment Form

This form is only to be completed by a licensed clinician. Licensed clinician may include but is not limited to Licensed Professional Counselor, Licensed Social Worker, Licensed Independent Clinical Social Worker, Licensed Alcohol and Drug Counselor, or Licensed Marriage and Family Therapist.

Client Name		*Date*	

Referral Information		
Referred by:	*Phone:*	*Date:*

Client Information				
Client Address				
Client Phone Number				
Date of Birth	MM/DD/YYYY			
Marital/Relationship Status				
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multiracial	*Ethnicity:* ☐ Hispanic ☐ Non-Hispanic ☐ Other			
Language	Primary:		Secondary:	
Gender Identity	☐ Male	☐ Female	☐ Transgender	☐ Wish not to Answer
Sexual Orientation				
Do you have a driver's license?	☐ Yes	☐ No		

Do you have a Social Security Card?	☐ Yes		☐ No	
Do you have a birth certificate?	☐ Yes		☐ No	
Do you have a HS Diploma or GED?	☐ Yes		☐ No	
Emergency Contact				
Name		*Relation*		*Phone*	
Environment				
What is your current living situation?				
Which of these activities can you complete independently?	☐ Manage Your Finances	☐ Take a Bath or Shower	☐ Take Medications	☐ Use the Bathroom
	☐ Prepare a Meal	☐ Dress Yourself	☐ Eat a Meal	☐ Drive a Car
Medical History				
List of Current Medications	*1.*	Dosage:	Frequency:	
	2.	Dosage:	Frequency:	
	3.	Dosage:	Frequency:	
	4.	Dosage:	Frequency:	
Comments on Medication Efficacy/Side Effects				
Are you pregnant?	☐ Yes	☐ No		
Do you have a physical disability?	☐ Yes	☐ No		
If yes, please describe:				

Do you have a developmental disability?	☐ Yes		☐ No
If yes, please describe:			
Do you have HIV/AIDS?	☐ Yes		☐ No
Do you have Hep A/B/C?	☐ Yes		☐ No
Have you been diagnosed with any behavioral health disorders?	☐ Yes		☐ No
If yes, please describe and list treatment received.			
Please list any medical conditions, current health needs, relevant health history, etc.			
Substance Use History			
	Date of last use	*Frequency of Use*	*Avg. amount used*
Tobacco/Nicotine Products			
Alcohol			
Cocaine			
Heroin			
Other Opiates			
Marijuana			
Methamphetamines			
Benzodiazepines			
Hallucinogens			
Synthetic			
Have you ever visited a Harm Reduction Program?	☐ Yes	☐ No	
Employment History			
Employment Status	☐ Employed	☐ Unemployed	

Major Field of Employment		
What is the duration of your current employment status?		
Source of Income (check all that apply)	☐ Employment	☐ Public Assistance
	☐ Retirement	☐ SSI or SSDI
	☐ Medical Disability	☐ Other:

Military History

☐ Active	☐ Discharged/Retired	☐ No Affiliation
Branch:	Length of service:	

Legal Status

Are you a convicted felon?	☐ Yes	☐ No
Are you required by the courts or any legal entity to enter this program?	☐ Yes	☐ No
Are you currently involved in any legal proceedings?	☐ Yes	☐ No
Are you currently on probation or parole?	☐ Yes	☐ No
Are you required to register as a sex offender?	☐ Yes	☐ No

If yes to any of the above, please explain (county, charge, lawyer, etc):

DHHR/CPS Information

How many children do you have?		
Do you have a CPS case?	☐ *Yes*	☐ No
If yes:	*County:*	
Do you have a CPS case?	*CPS Worker Phone:*	
	CPS Lawyer Name:	

	CPS Lawyer Phone:	

In the last 30 days, have you received?			
SSI	☐ Yes	☐ No	*Amount:*
SSDI	☐ Yes	☐ No	*Amount:*
Veteran's Disability	☐ Yes	☐ No	*Amount:*
TANF	☐ Yes	☐ No	*Amount:*
Worker's Comp	☐ Yes	☐ No	
SNAP	☐ Yes	☐ No	
Medicaid	☐ Yes	☐ No	
Medicare	☐ Yes	☐ No	
CHIPS	☐ Yes	☐ No	
WIC	☐ Yes	☐ No	
VA Medical Services	☐ Yes	☐ No	
Section 8/Public Housing	☐ Yes	☐ No	

Please explain why you are interested in entering our program:

____ Date: ______________________
Client Signature

____ Date: _______________________________
Provider Signature