Psychiatric Mental Health Survey

(First, MI, Last)	Age	Date of Birth
Psychiatrist (Name and Phone number):		Today's Date
Primary Care Provider (Name and Phone number):		
Who Referred You?		
What are the current concerns? List in order of importance. 1._____ _____ 2._____ _____ 3._____ _____		

Mental Health Treatment History	Place(s) and Date(s)
☐ Psychiatric Consultation	
☐ Outpatient Therapy/Counseling	
☐ Inpatient Hospitalization	
☐ Partial Hospitalization (Hospital-Based)	
☐ Day Treatment (Alternative School or School-Based)	
☐ Chemical Dependency Treatment	
☐ In-home Family Therapy	
☐ Psychological testing (IEP, IQ, achievement, etc.)	
Are there other ways that you have attempted to deal with the concerns?	
1.	
2.	
3.	

SYMPTOMS RATING CHECKLIST: Read each item below and RATE how much you have been bothered by the problem during the past month. **(0 = Not at all 1 = Rarely 2 = Sometimes 3 = Often)**	
NEURO-Behavioral SYMPTOMS	
	Less attentive to details or making careless mistakes in schoolwork, work, or activities
	Difficulty sustaining attention in tasks
	Does not seem to be listening when spoken to directly
	Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
	Has a difficult time organizing tasks and activities (e.g. managing sequential tasks, organizing materials, etc.)
	Avoids or dislikes or is reluctant to engage in tasks that require sustained mental effort
	Loses things necessary for tasks or activities
	Is distracted by extraneous stimuli (for adolescents and adults this may include unrelated thoughts)
	Is forgetful in daily activities (e.g., doing chores, running errands, keeping appointments, etc.)
	Fidgets with or taps hands and feet or squirms in seat
	Leaves seat in situations when remaining seated is expected
	Runs about or climbs in situations where it is inappropriate (or feelings of restlessness in adolescents/adults)
	Unable to play or engage in leisure activities quietly
	Is “on the go”, acting as if “driven by a motor” (e.g. unable to sit still for extended periods of time)
	Talks excessively
	Blurts out an answer before a question has been completed
	Has difficulty waiting your turn
	Interrupts or intrudes on others (e.g. butts into games, conversations or activities, uses others’ things)
	Intellectual or cognitive impairment or delays
	Speech or language problems
	Has difficulty in reading (word reading accuracy, reading rate or fluency, reading comprehension)
	Has difficulty in mathematics (number sense, memorization of math facts, accuracy or fluency, reasoning)
	Has difficulty in written expression (spelling, grammar/punctuation, clarity or organization)
	Motor/coordination problems
	Vocal/motor tics (e.g., repetitive eye blinking, throat clearing, facial movements, noises, etc.)
	Do you have difficulty with social communication and social interaction across multiple contexts/settings. **IF YES, CHECK THOSE BELOW THAT APPLY.**
	☐ Deficits in social-emotional interactions (e.g. approaching others abnormally, failing to converse back and forth, doesn’t share interests or feelings, fails to initiate or respond to social interactions, etc.)
	☐ Deficits in nonverbal communication (e.g. abnormal eye contact or body language, lack of facial expression, trouble understanding or using gestures)
	☐ Trouble developing or keeping friendships at a level expected for developmental age
	Restricted, repetitive patterns of behavior, interest, use of objects or speech. **IF YES, CHECK THOSE BELOW THAT APPLY.**
	☐ Repetitive patterns of behavior, interests, use of objects, or speech.
	☐ Repetitive or unusual motor movements, use of objects or speech
	☐ Insistence on things being the same, inflexible routines or patterns of verbal/nonverbal behavior
	☐ Highly restricted interests that are abnormal in intensity or focus
	☐ Under or over-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. indifference to pain/temperature, over response to textures, smells, light, movement, sounds, or tastes)

DISRUPTIVE BEHAVIOR SYMPTOMS (you or someone close to you may have noticed these symptoms about you)	
	Loses temper
	Touchy and easily annoyed
	Angry and resentful
	Argues with adults
	Actively defies or refuses to comply with rules or requests from authority figures
	Deliberately annoys others
	Blames others for own mistakes or misbehavior
	Spiteful or vindictive
	Behavioral outbursts involving verbal or physical aggression
	Bullies, threatens or intimidates other
	Initiates physical fights
	Used a weapon that can cause serious physical harm to others
	Physically cruel to people or animals
	Has stolen while confronting a victim
	Forced someone into sexual activity
	Deliberately engaged in fire setting with the intention of causing damage
	Deliberately destroyed others' property
	Broke into someone's house, building, or car
	Lies in order to obtain favors or to avoid obligations
	Has stolen without confrontation (e.g., forgery, shoplifting)
	Stays out at night without permission
	Has run away from home overnight
	Has been truant
	Verbal aggression or physical aggression toward property, animals, or other individuals, not resulting in physical injury to animals or other individuals.
	Behavioral outbursts involving damage or destruction of property and/or physical assault involving injury against animals or other individuals within a 12 month period.
MOOD SYMPTOMS (you or someone close to you may have noticed these symptoms about you)	
	Temper outbursts manifested verbally and/or behaviorally, that are out of proportion to the situation and are inconsistent with developmental level
	The mood in between temper outbursts is persistently irritable or angry
	Depressed or irritable mood
	Less interest or pleasure in all or almost all activities
	Significant weight loss when not dieting or weight gain (greater than 5% of body weight in a month)
	Difficulty sleeping or oversleeping
	Increased movement and agitation or decreased movement and slowing down
	Fatigue or loss of energy
	Feelings of worthlessness or excessive and inappropriate guilt
	Difficulty thinking or concentrating, or indecisiveness
	Thoughts of death, or suicidal thoughts (with or without a specific plan), or suicide attempt(s)
	Has had a *distinct* period of abnormally and persistently elevated (happy, excited) or irritable mood *and* abnormally and persistently increased goal-directed activity or energy. **IF YES, CHECK THOSE BELOW THAT APPLY.**
	☐ At least 4 days of noticeably increased, inflated self esteem or grandiosity
	☐ At least 4 days of noticeably decreased need for sleep (e.g. feels rested on 3 hours of sleep)
	☐ At least 4 days of noticeably increased talkativeness or pressure to keep talking
	☐ At least 4 days of noticeably increased racing thoughts or flight of ideas
	☐ At least 4 days of noticeably increased distractibility
	☐ At least 4 days of noticeably increased goal-directed activity or motor agitation (purposeless activity)
	☐ At least 4 days of noticeably excessive involvement in high risk activities

ANXIETY SYMPTOMS (you or someone close to you may have noticed these symptoms about you)	
	Fear and anxiety concerning separation from home or major attachment figures
	Failure to speak in certain social situations (e.g., school or with unfamiliar adults) but speaking ok at home
	Marked fear/anxiety about a specific object or situation (e.g., heights, animals, the dark)
	Marked fear/anxiety about social situations involving being observed by others (e.g., performing, conversing)
	Panic attacks (sudden onset of intense fear or physical discomfort that reaches a peak within minutes)
	Anxiety and worry about a number of events or activities, occurring more days than not
OBSESSIVE-COMPULSIVE SYMPTOMS (you or someone close to you may have noticed these symptoms about you)	
	Recurrent and persistent thoughts, urges, or images that cause marked anxiety or distress
	Repetitive behaviors (e.g., hand washing, checking) or mental acts (e.g., praying, counting) that the individual feels driven to perform in response to an obsession or according to rules that must be rigidly applied
	Preoccupation with perceived defects or flaws in physical appearance that are not observable to others
	Difficulty discarding or parting with possessions, regardless of their value (i.e., hoarding)
	Hair pulling
	Skin picking
Before the age of 25 Trauma Related Symptoms (Do you recall ever having any of these symptoms as a child or young adult or now)	
	Has experienced a pattern of extreme, insufficient care (e.g., neglect, deprivation, changes in caregivers, etc.) **IF YES, CHECK THOSE THAT APPLY**
	☐ Rarely or minimally seeks or responds to comfort from caregivers when upset or distressed
	☐ Minimal social and emotional responsiveness to others
	☐ Limited positive emotions
	☐ Episodes of unexplained irritability, sadness or fearfulness during interactions with adult caregivers
	☐ Reduced caution in approaching and interacting with unfamiliar adults
	☐ A pattern of actively approaching and interacting with unfamiliar adults (e.g., a willingness to go off with unfamiliar adults with little or no hesitation, being overly familiar, not checking back with caregivers after venturing away, etc.)
	Has had exposure to actual or threatened death, serious injury, or sexual violence **IF YES, CHECK THOSE THAT APPLY**
	☐ Recurrent, distressing memories or dreams of the traumatic event
	☐ Re-enactment of the traumatic event in repetitive play activities
	☐ Intense, physical or emotional distress when exposed to reminders of the traumatic event
	☐ Flashbacks of the traumatic event (i.e., feeling or acting as if the traumatic events were recurring)
	☐ Persistent avoidance of memories, thoughts, feelings, places or objects associated with the traumatic event
	☐ Negative changes in thoughts or mood beginning or worsening after the traumatic event (e.g., guilt, shame, loss of interest, feeling detached, self-blame, etc)
	☐ Marked changes in arousal or reactivity, beginning or worsening after the traumatic event (e.g. angry outbursts, hypervigilance, problems sleeping, reckless/destructive behavior, etc.)
DISTORTED THINKING OR PERCEPTION SYMPTOMS (you or someone close to you may have noticed these symptoms about you)	
	Delusions (i.e., persistent odd or false beliefs)
	Hallucinations (i.e., hearing or seeing things that are not really there)
DISORDERED EATING SYMPTOMS (you or someone close to you may have noticed these symptoms about you)	
	Episodes of binge eating
	Inappropriate behaviors used to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives or diuretics, fasting, excessive exercise, etc.)
	Restriction of food intake leading to significantly low body weight (i.e., less than minimally expected)
	Fear of gaining weight or becoming fat

	Disturbance in the way in which one's body weight or shape is experienced

MISCELLANEOUS SYMPTOMS

Are there other symptoms or concerns that you have about this child/adolescent?

Risk Indicators (Check all that apply)

	Do you wish to be dead: have you had thoughts about a wish to be dead or not live anymore, or a wish to not wake up?
	Have you had or do you have non-specific thoughts of wanting to end life/die by suicide?
	Suicide Behavior: have you ever attempted suicide, OR been interrupted in attempting, OR other taken steps to enact a plan?
	Self-injurious behavior ***without*** suicidal intent: other ways to cause yourself non-lethal physical pain
	Method for suicide available (gun, pills, etc.)
	☐No firearms in the home ☐Firearms are easily accessed ☐Use of safe firearm and ammunition storage practices
	Family history of suicide (lifetime)
	Recent loss or other significant negative event(s) (legal, financial, relationship, etc.)
	Do you have any arrests OR pending incarceration?
	Current or pending isolation or feeling alone?
	Do you have feelings of hopelessness?
	Command hallucinations to hurt self
	Do you think you have highly impulsive behavior?
	Do you use illicit drugs or alcohol to cope with stress?
	Do you perceive yourself a burden on family or others?
	Do you have any chronic physical pain or other acute medical problem?
	Do you have any homicidal thoughts/preoccupation with violence/ desire or fantasy to harm or kill someone?
	Do you demonstrate aggressive behavior toward others?
	Have you ever had sex with an adult when you were a minor or any forced sexual encounters perpetrated upon you?
	Who makes up your social group/ peer group?
	Have you forced any sexual acts upon someone?

Parents' marital status: ☐never married. ☐married for _____ years. ☐separated. ☐divorced.

If parents are divorced, describe physical and legal custody?

Who lives in the home with you? Name	Age	Relation	Health Status:
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor

List any immediate family members who do not live with you and any deceased family members:

Name	Living	Age	Relation	City, State
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			

Developmental History (only for patients under age 25)

Prenatal and Delivery History

How was the mother's overall health during pregnancy with this patient?: ☐good ☐fair ☐poor ☐don't know

How was the mother's overall health during pregnancy with this patient?: ☐good ☐fair ☐poor ☐don't know

Did the mother experience any medical problems or complications during pregnancy? ☐Yes ☐No
If yes, please specify:

How old **were** the parents when this patient was born? Mother _____ Father _____

What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?
☐Alcohol: Describe amount and frequency. _____
☐Tobacco: Describe amount and frequency. _____
☐Street Drugs: Describe what drugs, amount and frequency. _____
_____
☐Prescription Drugs: Describe what drugs, amount and frequency. _____
_____

Was this child/adolescent born: ☐less than 30 weeks gestation ☐30-35 weeks ☐36-40 weeks ☐over 40 weeks

Was delivery: ☐Normal ☐Breech ☐Caesarian ☐Forceps/vacuum assisted ☐Induced

What was the child/adolescent's birth weight? _____

Were there indications of fetal distress during labor/birth? ☐Yes ☐No
If yes, please specify _____

Were there any health complications following birth? ☐Yes ☐No
If yes, please specify _____

Postnatal Period and Infancy

Were there any infancy feeding problems? ☐Yes ☐No
If yes, please specify _____

Was this child/adolescent colicky as an infant? ☐Yes ☐No
If yes, please specify _____

Were there infancy sleep pattern difficulties? ☐Yes ☐No
If yes, please specify _____

Were there problems with responsiveness/alertness during infancy? ☐Yes ☐No
If yes, please specify _____

How easy was this child/adolescent as a baby?
☐Very easy ☐Easy ☐Average ☐Difficult ☐Very Difficult

Were there any concerns about this child/adolescent's attachment to the primary caregiver(s)? ☐Yes ☐No
If Yes, please specify _____

Toddler Period

As an infant/toddler, how did this child/adolescent behave with other people?

☐More sociable than average ☐Average sociability ☐Actively avoided socializing ☐More shy than average

As an infant/toddler, how insistent was this child/adolescent when he or she wanted something ?

☐Very insistent ☐Somewhat insistent ☐Average ☐Passive

As an infant/toddler, how active was this child/adolescent?

☐Very active ☐Active ☐Average ☐Less active ☐Very inactive

How would you describe this child's play as an infant/toddler? (Check all that apply)

☐Loud ☐Interested in playing with others ☐Imaginative / Make believe

☐Quiet ☐Played alone ☐Repetitive ☐Rigid, concrete

Developmental Milestones

Have you or anyone else ever had concerns about this child/adolescent's development? ☐Yes ☐No

If yes, please specify _____

At what age (in months) did this child/adolescent:

Sit up? _____ Crawl? _____ Walk? _____

At what age (in months) did this child/adolescent speak single words (other than "Mama" or "Dada")? _____

At what age (in months) did this child/adolescent begin stringing two or more words together? _____

At what age (in months) was this child toilet trained? For bladder _____ For bowel _____

Medical History (all patients)

How would your overall health?

☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor

How is your hearing? ☐Good ☐Fair ☐Poor Fine motor coordination? ☐Good ☐Fair ☐Poor

Vision? ☐Good ☐Fair ☐Poor Gross motor coordination? ☐Good ☐Fair ☐Poor

Speech and language? ☐Good ☐Fair ☐Poor

Have you ever had or have any chronic health problems (e.g., asthma, diabetes, allergies, heart condition)? ☐Yes ☐No

If yes, please specify _____

Which of the following illnesses have you had? Check all that apply:

☐Chronic diarrhea ☐Stomach aches ☐High fevers ☐Chronic pain ☐Chronic ear infections

☐Constipation ☐Allergies ☐Encephalitis ☐Chronic headaches ☐Lead poisoning

☐Asthma ☐Croup ☐RSV ☐Chicken pox ☐Urinary tract infections

☐Pneumonia ☐Seizures ☐Meningitis ☐Other _____

Have you had any medical problems aside from the usual childhood illnesses? ☐Yes ☐No
If yes, please specify _____

Have you ever been hospitalized? ☐Yes ☐No
If yes, please specify the reason, date, outcome and name of hospital. _____
_____
_____

Have you ever had any emergency room visits for emotional or behavioral problems? ☐Yes ☐No
If yes, please specify the reason, date, outcome and name of hospital. _____
_____
_____

Have you ever received medication for emotional, physical, learning or behavioral problems? ☐Yes ☐No
If yes, please specify:

Medication #1: _____
Reason prescribed? _____
Daily Dose: _____
Who Prescribed This?: _____
How long was this taken?: _____
Was this helpful? _____
Side effects: _____

Medication #2: _____
Reason prescribed? _____
Daily Dose: _____
Who Prescribed This? _____
How long was this taken? _____
Was this helpful? _____
Side effects: _____

Medication #3: _____
Reason prescribed? _____
Daily Dose: _____
Who Prescribed This? _____
How long was this taken? _____
Was this helpful? _____
Side effects: _____

Medication #4: _____
Reason prescribed? _____
Daily Dose: _____
Who Prescribed This? _____
How long was this taken? _____
Was this helpful? _____
Side effects: _____

Medication #5: _____
Reason prescribed? _____
Daily Dose: _____
Who Prescribed This? _____
How long was this taken? _____
Was this helpful? _____
Side effects: _____

Medication #6: _____
Reason prescribed? _____
Daily Dose: _____
Who Prescribed This? _____
How long was this taken? _____
Was this helpful? _____
Side effects: _____

Has you had any accidents resulting in the following? (Check all that apply)

☐Sutures ☐Broken bones ☐Severe lacerations ☐Head injury
☐Severe bruises ☐Loss of teeth ☐Loss of consciousness ☐Eye injury

Please explain the injury: _____

Have you had or do you have any bladder control problems?: ☐No ☐Yes
If yes, are these … ☐During the day? ☐During the night?

Have you had or do you have any bowel control problems?: ☐No ☐Yes
If yes, are these … ☐During the day? ☐During the night?

When is your usual bedtime ?: _____ work/school nights. _____ weekend/ holiday/ vacation.

Describe your sleep patterns or habits:
☐Sleeps all night without disturbance ☐Has trouble falling asleep ☐TV in bedroom ☐Early morning awakening
☐Awakens during night/restless sleeper ☐ Screen time up to bedtime ☐Severe snoring ☐Sleeps outside bedroom
☐ Gets out of bed in middle of the night ❑ Sleeps with parent(s)

Describe your eating habits:
☐Overeats ☐Average ☐Under eats ☐Binge eating ☐Intentionally restricts intake

Family Health History

	Mother	Father	Sibling	Describe the disability or health problem
Family member disability?				
Family member serious health problems?				

Family Health History

Check all that apply to biological family	Mother	Maternal family	Father	Paternal family	Siblings
Heart Problems					
Thyroid Problems					
Problems with inattention, hyperactivity/ impulse control.					
Problems with aggression, oppositional, or antisocial behavior as a child.					
Learning disabilities					
Cognitive/intellectual disabilities					
Autism Spectrum					
Anxiety					

Depression					
Obsessive Compulsive Disorder					
Eating Disorder					
Schizophrenia or Psychosis					
Bipolar Disorder					
Suicidal thoughts or attempts					
Drug abuse or dependence					
Victim of sexual abuse					
Victim of physical abuse					
Other: (specify)					

Cultural, Spiritual Influences

Describe any important spiritual/religious/cultural influences that are important in understanding your problems or treatment:

_____

_____

Life Stressors/Trauma History

Have you experienced or witnessed any of the following? (Check all that apply)

☐ Domestic violence/abuse: Explain _____

☐ Community violence: Explain _____

☐ Physical abuse: Explain _____

☐ Verbal or Emotional abuse: Explain _____

☐ Sexual assault/molestation: Explain _____

☐ Physical neglect: Explain _____
☐ Serious illness: Explain _____
☐ Serious accident : Explain _____
☐ Divorce/Separation/Remarriage of Parent: Explain _____
☐ Change of residence: Explain _____
☐ Change of schools: Explain _____
☐ Job changes of parents: Explain _____
☐ Pregnancy/Miscarriage/Abortion: Explain _____
☐ Family chemical abuse: Explain _____
☐ Exposure to drug activity (outside of the home): Explain _____
☐ Foster care or other out-of-home placement: Explain_____
☐ Arrests/Imprisonments in family: Explain _____
☐ Death/loss of family member: Explain _____
☐ Death/loss of friend: Explain _____
☐ Family accident or illness: Explain _____
☐ Financial changes or stressors: Explain _____
☐ Parent conflicts in disciplining: Explain _____
☐ Other: Explain _____

Strengths and Quality of Social Network

What are your strengths?

1. _____ 3. _____
2. _____ 4. _____

What do you like to do?
Activities: _____
Hobbies: _____

Describe your relationship with each parent:
Mother: _____
Father: _____
Step mother: _____
Step father: _____
Spouse: _____
Children:_____

Describe your relationship with siblings:
_____
_____

Describe your relationship with peers:
_____
_____

Educational History

Does you have an IEP for special education services?: ☐No ☐Yes

If no, has your child ever been tested and determined not to need services? ☐No ☐Yes

Any major recollections from the years in school

Grade	Progress	School/Program
Preschool/ Daycare		
Kindergarten		
1st grade		
2nd grade		
3rd grade		
4th grade		
5th grade		
6th grade		
7th grade		
8th grade		
9th grade		
10th grade		
11th grade		
12th grade		

Did you repeat any grades? ☐Yes ☐No

If yes, please specify which grade and why: _____

_____

Did you participate in any special education or other programming? If so, indicate which grade(s).

Program	Grade(s)	Program	Grade(s)
Early Childhood Spec. Ed./Developmental Delay	_____	Developmental/Cognitive Disability	_____
Special Learning Disability	_____	Autism Spectrum Disorder	_____

What were your strengths in school? _____

What were your weaknesses in school? _____

Do you think your school did a good job meeting your needs? _____

Are you currently employed? If yes, where and how many hours/week? _____

Alcohol / Substance Use

Do you drink alcohol? ☐Yes ☐No

Have you ever experimented with drugs? ☐Yes ☐No

If you responded "no" to both questions, you can STOP here. Thank you for providing us with this important information.

If you responded "yes" to one or both questions, please complete the remaining questions:

CAGE-AID Questions (to be completed by a child/adolescent age 12 and up)

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Which category of mood altering substances have you used?

☐Alcohol ☐Prescription drugs ☐Street drugs ☐Over-the-counter drugs ☐None known

Please name all mood-altering substances you have used:

How many years altogether have you been using drugs? _____

How would you describe your pattern of alcohol or chemical use"?

☐Continuous and progressive ☐On and off with no pattern ☐A fairly regular pattern ☐Decreasing but more destructive

Have you shown signs of significant mood changes? ☐Yes ☐No

If yes, please explain:

The following is a list of common symptoms in individuals who are abusing alcohol or drugs. Please check all that apply.

☐ Blackouts. How often: _____

☐ Minimizes the extent of their use. Describe: _____

☐ Lies about where they go or who they are with. When did this start? _____

☐ Engages in abusive or aggressive behavior. Describe: _____

☐ Uses mood altering drugs/medications when drinking or substitutes medications for alcohol?

☐ Stops drinking for periods of time. How often and why? _____

☐ There have been changes in pattern. Describe: _____

_____

☐ Drinking and/or chemical use has resulted in changes in usual activities. Describe: _____

_____

☐ Have you become more resentful of people or situations? Describe:

_____

_____

☐Changes in sexual drive or activity. Describe: _____

☐ Binges or benders. Describe: _____

☐Tremors or alcohol/drug related physical problems. Describe: _____

☐ Narrowed range or lack of interests. Describe: _____

☐Changes in the type of friends or attitudes toward friends. Describe: _____

_____

☐Left or threatened to leave home after being confronted about chemical use. Describe: _____

_____

☐Was told by a physician that chemical use is injuring his/her health. Describe: _____

_____

☐Family members have complained that you spend too much money on alcohol or other chemicals. Describe:

_____

☐ Have you quit or been threatened with expulsion or suspension from work or school due to chemical use. Describe: _____

_____

☐ Have you been picked up/arrested by police for intoxication or other chemical use related charges. Describe: _____

_____

☐Has had accidents/injuries related to drinking or chemical use. When/Describe: _____

_____

☐Has had illnesses related to drinking or chemical use. When/Describe: _____

_____

☐Has been gone from home without notifying a loved one. When/Describe: _____

_____

☐Has had other negative consequences related to drinking or substance use. Describe: _____

_____

I feel responsible for my drinking/chemical use? ☐Yes ☐No

I sometimes feel guilty about drinking/chemical use? ☐Yes ☐No

I feel this I could quit drinking/using if I wanted to badly enough? ☐Yes ☐No

I simply lacks the will power to quit drinking/using? ☐Yes ☐No

Alcoholism is not a disease so much as it is a sin and moral problem? ☐Yes ☐No

I feel that I am not alcoholic or chemically dependent but rather has a drinking/use problem? ☐Yes ☐No