Mindy LaFramboise, MA, LPC
Licensed Professional Counselor
Office address: 123 E Powell Blvd, Ste 212● Gresham, Oregon ● 97030 ● www.MindyLaframboise.com
Mail to: 2870 NE Hogan Rd, Ste #213 ● Gresham, Oregon ● 97030● 503.328.8715● Fax 503.328.8764

Client Self Assessment at Intake

Client Name:_____ Date:_____

Please take a moment to tell me about yourself. The more I know about your situation, the more effective I will be in helping you.

A. Reasons for Treatment Please check all the reasons you have for coming to treatment.
I have a problem with:

__ symptoms (like stress, anxiety, sadness, depression, etc)
__ my partner, spouse, boyfriend, girlfriend
__ my job or school
__ daily living skills
__ problem behaviors
__ my finances
__ alcohol or Drugs
__ legal (probation, etc)
__ my family
__ need an evaluation only
__ where I live
__ gambling

__ another problem not mentioned: _____

Please describe your reason for coming to treatment:_____

_____

B. Health History Answer each. Showing which condition or health problem you have, have had, or never had in the past. Caregiver, please answer for the child if the child is the client named above.

	Now	Past	Never		Now	Past	Never
Cancer	□	□	□	Heart Condition	□	□	□
Stroke	□	□	□	Asthma	□	□	□
Allergies	□	□	□	Emphysema	□	□	□
Arthritis	□	□	□	Thyroid Disorder	□	□	□
HIV/AIDS	□	□	□	Digestive Disorder	□	□	□
STD (herpes, etc)	□	□	□	Menopause	□	□	□
Seizure Disorder	□	□	□	Parkinson's	□	□	□
Head Trauma	□	□	□	Hearing Impairment	□	□	□
Physical Disability	□	□	□	Developmental Disability	□	□	□
Back Problems	□	□	□	Dental Problems	□	□	□
Chronic Pain	□	□	□	Obesity	□	□	□
High Blood Pressure	□	□	□	COPD	□	□	□
Diabetes	□	□	□	Kidney Disease	□	□	□
Urinary Condition	□	□	□	Pregnancy	□	□	□
Alzheimer/ Dementia	□	□	□	Visual Impairment	□	□	□
Frequent Falls	□	□	□	Migraine / Headaches	□	□	□

Other:_____

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C. Family Medical History Indicate any of the conditions above for your relatives or, if caregiver, indicate your child's relatives. Please include substance abuse, mental health and/or psychiatric problems.

Mother:_____ Father:_____

Sibling:_____ Sibling:_____

Other / Relationship:_____

Other / Relationship:_____

D. Current Medications Please list your current medications. If caregiver, please list child's current medications.

Medication	For	Dosage

E. Personal History Caregivers, please answer for the child.

	Yes	No	
Have you ever been arrested?	☐	☐	If yes, describe_____
Have you ever been convicted of a crime?	☐	☐	If yes, describe_____
Have you ever physically harmed someone?	☐	☐	If yes, describe_____
Is there a gun in the home or access to a gun?	☐	☐	
Has anyone expressed concerns about you being violent?	☐	☐	If yes, describe_____
Have you ever had a DUII/MIP?	☐	☐	
Have you ever been sexually or physically abused?	☐	☐	
Have you ever been the victim of a violent crime?	☐	☐	
Are you concerned about someone being violent to you?	☐	☐	If yes, describe_____

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E. Personal History (continued) Caregivers, please answer for the child.

	Yes	No
Have you felt down or depressed for 2 or more weeks?	☐	☐
Have you lost interest in normally interesting things?	☐	☐
Have you felt hopeless about your future?	☐	☐
Have you had anxiety or panic attacks?	☐	☐
Have you gambled in the last 2 months?	☐	☐

If yes, have you ever felt the need to bet more and more money? ☐ Yes ☐ No

If yes, have you ever lied to people important to you about how much you've gambled? ☐ Yes ☐ No

Have you ever had any experience that was so frightening, horrible,, or upsetting, that in the last month you've:

had nightmares or thoughts about it when you didn't want to? ☐ Yes ☐ No

tried hard not think about it or went out of your way to avoid situations that remind you of it? ☐ Yes ☐ No

were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No

felt numb or detached from others, activities, or surroundings? ☐ Yes ☐ No

F. Substance Use Inventory

Have you ever used any of the following? Please indicate if there are any family members who are impacted by any of the substances listed. Please list their relationship (father, sister, grandparent, etc): Caregivers, please answer for the child.

	Have you ever used?	
Alcohol	☐ Yes	☐ No
Marijuana	☐ Yes	☐ No
Hashish	☐ Yes	☐ No
Meth/Amphetamines	☐ Yes	☐ No
Cocaine/Crack	☐ Yes	☐ No
Heroin	☐ Yes	☐ No
Other Opiates	☐ Yes	☐ No
Non prescribed Methadone	☐ Yes	☐ No

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F. Substance Use Inventory (continued)

	Have you ever used?
Barbiturates	☐ Yes ☐ No
Other Sedative/Hypnotics	☐ Yes ☐ No
Hallucinogens	☐ Yes ☐ No
Inhalants	☐ Yes ☐ No
Over-The-Counter Drugs	☐ Yes ☐ No
Tranquilizers	☐ Yes ☐ No
Pain Killers (e.g. Percocet)	☐ Yes ☐ No
PCP (e.g. Angel Dust)	☐ Yes ☐ No
Nicotine	☐ Yes ☐ No
Caffeine	☐ Yes ☐ No
Other:	☐ Yes ☐ No
Other:	☐ Yes ☐ No

G. Strengths During the past year, which of the following do you consider to be your strengths **(Check all that apply)**?

☐ Doing well at school or training
☐ Doing well at work
☐ Doing well with your family
☐ Doing well with close friends
☐ Doing well at sports, exercise, or other physical activity
☐ Doing well at music, dance, drawing, or other performing arts
☐ Drawing, painting, design, or other art activity
☐ Listening, caring, and communicating with others
☐ Problem solving and figuring things out
☐ Working or playing with computers

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G. Strengths (continued)

What are your most important strengths as a person? (What would you tell someone you just met about what you're good at?)

1. _____

2. _____

3. _____

You are done! Thank you.