CAFA Client Information
921 Country Club Road, Suite 222, Eugene, OR 97401
Phone: 541-686-6000 Fax: 541-344-8239

Date: Therapist:

Identification

Your name: Date of Birth: Age:

Are you a former client? ❑Yes ❑No

Note: If you have been a patient here before, please fill in only the information that has changed.

Referral *(Who gave you my name to call? Referral source may be DHS/Probation/Court/etc?)*

Name: Phone:

Presenting Problem
Please describe the main difficulty that has brought you to see me: *(Precipitating events? Psychiatric hospital in the past year?)*

Presenting Symptoms *(symptoms bothering you the most)*

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before have you visited the Emergency Room (ER) with a mental health emergency? ❑Yes ❑No If yes, please indicate:

When	From Whom?	For What?	With what results?

Have you ever taken medications for psychiatric or emotional problems? ❑ Yes ❑ No - If yes, please indicate:

Psychiatric Medications:

Dates Taken	Medication Name	For What?	Prescribed by

Other Current Medications:

Medication Name	For What?	Prescribed by

Health History

How would you describe your nutritional habits? *Check all that apply*

- ☐ Very Healthy
- ☐ Healthy
- ☐ Unhealthy
- ☐ Balanced
- ☐ Calorie-counting
- ☐ High in Sugar
- ☐ High in Sodium
- ☐ Whatever is convenient
- ☐ Other: _____

Have your gained or lost more than 10 pounds in the last 6 months? ❑ Yes ❑ No

Height: _____ Weight: _____

Please list all major illnesses, surgeries and/or chronic issues you've experienced:

_____

_____

_____

From whom or where do you get your primary medical care?

Clinic/doctor's name: Phone: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Relationships in your family of origin

Please describe:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with any other adults present:

3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:

4. Your relationship with your siblings, in the past and present:

Abuse history

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For "Kind of Abuse", use these letters:
P= Physical, S = Sexual, N=Neglect, E = Emotional

Your age	Kind of abuse	By whom	Whom did you tell?	Were there consequences of telling?

Present relationships

1. How do you get along with your present spouse or partner?

2. How do you get along with your children?

3. Your important friends, past and present:

Names	Good parts of the relationship	Bad parts of relationship

Family of Origin Please list family members who were present during significant points in your upbringing.

	First Name	Current Age (or age at death)	Education Level	Occupation
Father				
Mother				
Stepparents				
Grandparents				
Uncles/Aunts				
Siblings				

Significant Relationships

	First Name of Partner	Length of Relationship	Reason for Ending the Relationship
First			
Second			
Third			
Current			

Children *(Name, Age & Gender)*

How do you spend your free time? *(Friends, people to talk to, hobbies, recreation, social anxiety, etc.)*

Educational History

School Name		Dates Attended Began	Ended
	Degree Obtained (Diploma/Bachelors/Masters) Special courses/focus: General Experience in this school:		
	Degree Obtained (Diploma/Bachelors/Masters) Special courses/focus: General Experience in this school:		

Employment & Military History (Begin with Current Employer)

Employer/Branch of Military Name	Position held / Job Title	Dates Employed Began	Ended

Current Employer

Employer: _____

Position/ Job Title: _____

Living Skills: (*Do you have difficulty with housekeeping, shopping, cooking, medication compliance, and hygiene? If so, please explain)*

_____

_____

_____

Finances: (*Do you money management problems? Trouble paying bills? If so, please explain.))*

_____

_____

_____

Housing Situation *check all that apply*

- ☐ Rent
- ☐ Own
- ☐ Lease
- ☐ # of people in household:
- ☐ House
- ☐ Apartment
- ☐ Shared Living
- ☐ Permanent
- ☐ Temporary
- ☐ Other

Transportation

What is your mode of daily transportation? (Car, bus, bike, walk, etc)

_____

_____

Legal History

1. Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No
   If yes, please explain:

   _____

   _____

2. Is your reason for coming to see me related to an accident or injury? ❑ Yes ❑ No
   If yes, please explain:

   _____

   _____

3. Are you required by a court, the police, or a probation/parole office to have this appointment? ❑ Yes ❑ No
   If yes, please explain:

   _____

   _____

4. List all of the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.

Date	Charge	Sentence

5. Your current attorney's name:_____ Phone:_____
6. Are there any other legal involvements that I should know about?

   _____

Chemical use

How much beer, wine, or hard liquor do you consume each week, on the average?

Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ Yes ❑ No
Have you ever felt the need to cut down on your drinking? ❑ Yes ❑ No
Have you ever felt annoyed by criticism of your drinking? ❑ Yes ❑ No
Have you ever felt guilty about your drinking? ❑ Yes ❑ No
Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ Yes ❑ No
How many cups of regular coffee do you drink each day? _____
How many cups of tea each day? _____
How many sodas with caffeine each day? _____
How many energy drinks each day? _____
How often do you use NoDoz or similar pills each day? _____
Have you ever taken a morning "eye-opener"? _____
How much tobacco do you smoke or chew each week? _____
Which drugs (not medications prescribed for you) have you used in the last 10 years?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

Gambling *(How often? Do you buy lottery tickets? Compulsive betting?)*

How often do you access sexually stimulating material?

Ethnic & Religious Identification

Current religious denomination/affiliation: _____
How important are spiritual concerns in your life? _____
Which (if any) church, synagogue, temple, or meeting are you involved with? _____
Level if Involvement: ❑None ❑ Some/irregular ❑ Active

Ethnicity/national origin: Race:

Or other similar way you identify yourself and consider important or cultural consideration?

Risk Assessment

Do you have any thoughts/plans of harming yourself? ☐ Yes ☐ No
Have you ever attempted to harm yourself/suicide attempts? ☐ Yes ☐ No
If yes, please explain:

Do you have any thoughts/plans of harming anyone? ☐ Yes ☐ No
Have you ever attempted/planned to harm someone else? ☐ Yes ☐ No
If yes, please explain:

Personal Strengths

Client/Family Goals for Recovery/Therapy

Emergency Contact Information

If an emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: Phone: Relationship:

Address:

Significant other/nearest friend or relative not residing with you:

Name: Phone: Relationship:

Address:

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

Please do not write below this line.

Follow-up by clinician

Based on the responses above and on ❑ interview data ❑ records ❑ I reviewed ❑ other information

I have requested the client to complete and/or I have completed the following forms:

❑ Chemical use survey
❑ Suicide risk assessment summary and recommendations
❑ Other:

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.