

CARY BEHAVIORAL HEALTH PC

160 N.E. MAYNARD ROAD, SUITE # 200, CARY, NC 27513.

PHONE 919-466-7540 FAX 919-466-7543

SELF-ASSESSMENT

Please Print

Name		Date:	
Street		Suite/Apt. #	
City, State		Zip Code	
Phone (home)		Phone (cell/work)	
Age	Date of Birth (month/day/year)		
Emergency Contact		Relationship	
Street		Suite/Apt. #	
City, State		Zip Code	
Phone (home)		Phone (cell/work)	

Gender		Marital Status	
Female	<input type="checkbox"/>	Never Married	<input type="checkbox"/>
Male	<input type="checkbox"/>	Living Cooperatively	<input type="checkbox"/>
Occupation		Married	<input type="checkbox"/>
		Divorced	<input type="checkbox"/>
		If married, how many times?	If divorced, how many times?
		Separated	<input type="checkbox"/>
		Widow/Widower	<input type="checkbox"/>
Education (please specify highest year completed and degree)			
High School	College University	Graduate School	

Drinking (Alcohol Use)	Medical Problems	
How many drinks do you consume in the average day? At what time of day do you have your first drink? What is the most you have had to drink in a 24hr period during the last year? Check if you have ever felt you were or someone told you that you were drinking too much. <input type="checkbox"/> If "yes", what were the circumstances?	Age when first occurred	List all past & present medical problems as well as any surgery or accident.
Drugs of Abuse Check if you have taken any of the following drugs.		
None <input type="checkbox"/> Marijuana <input type="checkbox"/> Amphetamines/speed <input type="checkbox"/> Heroin/opiates <input type="checkbox"/> PCP <input type="checkbox"/> LSD/hallucinogens <input type="checkbox"/> Cocaine/crack <input type="checkbox"/> Barbiturates/sedatives/downers <input type="checkbox"/> If you checked one or more of the drugs, under what circumstances did you take it (them). When did you most heavily use drugs? When was the last time you took such drugs?		
Personal History Check any items that apply to you	Family History/Major Illness (Include mental illness)	
Mothers pregnancy with you was abnormal <input type="checkbox"/> Mothers delivery of you was abnormal <input type="checkbox"/> Check if during childhood you... Were afraid to go to school <input type="checkbox"/> Had difficulty with reading, writing, or math <input type="checkbox"/> Were truant <input type="checkbox"/> Failed or repeated a grade <input type="checkbox"/> Had frequent falls <input type="checkbox"/> Were awkward at games <input type="checkbox"/> Wet bed after age 5 <input type="checkbox"/> Had tics <input type="checkbox"/> Had trouble with eyes <input type="checkbox"/> Were (are) left handed <input type="checkbox"/> Mispronounced words, had a lisp, stutter/stammer <input type="checkbox"/> Had nightmares, disturbed sleep, fear of the dark <input type="checkbox"/> Ran away from home <input type="checkbox"/> Were cruel to animals <input type="checkbox"/> Often lied to families or others <input type="checkbox"/> Set fires <input type="checkbox"/> Moved often <input type="checkbox"/> Were exposed to incest <input type="checkbox"/> Were promiscuous <input type="checkbox"/>	Mother : _____ Father: _____ Siblings: _____ _____ _____ Children: _____ _____ _____ Grandparents, Aunts/Uncles: _____ _____ _____	

Mothers pregnancy with you was abnormal	<input type="checkbox"/>
Mothers delivery of you was abnormal	<input type="checkbox"/>
Check if during childhood you...	
Were afraid to go to school	<input type="checkbox"/>
Had difficulty with reading, writing, or math	<input type="checkbox"/>
Were truant	<input type="checkbox"/>
Failed or repeated a grade	<input type="checkbox"/>
Had frequent falls	<input type="checkbox"/>
Were awkward at games	<input type="checkbox"/>
Wet bed after age 5	<input type="checkbox"/>
Had tics	<input type="checkbox"/>
Had trouble with eyes	<input type="checkbox"/>
Were (are) left handed	<input type="checkbox"/>
Mispronounced words, had a lisp, stutter/stammer	<input type="checkbox"/>
Had nightmares, disturbed sleep, fear of the dark	<input type="checkbox"/>
Ran away from home	<input type="checkbox"/>
Were cruel to animals	<input type="checkbox"/>
Often lied to families or others	<input type="checkbox"/>
Set fires	<input type="checkbox"/>
Moved often	<input type="checkbox"/>
Were exposed to incest	<input type="checkbox"/>
Were promiscuous	<input type="checkbox"/>

Mother : _____

Father: _____

Siblings: _____

Children: _____

Grandparents, Aunts/Uncles: _____

Medical History	Suicide
Weight and Height	Check if you have ever thought about suicide <input type="checkbox"/>
What is your current weight in pounds? lbs.	If yes, when was the last time?
Check if your weight has increased/decreased by more than 10 lbs. during the last 5 years. <input type="checkbox"/>	Check if you have ever attempted suicide <input type="checkbox"/>
If checked, explain the circumstances	If yes, when and how?
What is your height?	Check if you have thoughts about suicide now <input type="checkbox"/>
Sleep (Check any items that apply to you)	Injury to others
Have difficulty falling asleep <input type="checkbox"/>	Check if you have ever thought about hurting someone else <input type="checkbox"/>
Have difficulty waking up & falling back to sleep <input type="checkbox"/>	If yes, when was the last time?
Are tired on waking <input type="checkbox"/>	Check if you have ever hurt someone else <input type="checkbox"/>
Have bad dreams, sleep walk, or other sleep disturbances <input type="checkbox"/>	If yes, when and how?
Have sleep apnea or snoring <input type="checkbox"/>	Check if you are thinking about hurting someone else now <input type="checkbox"/>
Smoking	Recent Stressful Life Events
Check if you smoke <input type="checkbox"/>	Check any of the following events that have occurred during the last 2 years.
If checked, how much & for how long?	Married <input type="checkbox"/>
Caffeine	Engaged <input type="checkbox"/>

Check if you drink coffee, tea, or colas If checked, how much? <input type="checkbox"/>	Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Serious argument <input type="checkbox"/>
Allergies	Breakup of important relationship <input type="checkbox"/>
List all allergies. Be sure to include medication allergies.	Child left home <input type="checkbox"/> Death of spouse, other <input type="checkbox"/> Bad health (behavior) of family member <input type="checkbox"/> Difficulties with family member <input type="checkbox"/> Personal injury, illness <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Difficulties, changes at school, work <input type="checkbox"/>
Females- Menstrual History	Retired, lost job <input type="checkbox"/>
Check if your mood, depression, irritability, or irrationality changes with your periods. If checked, how? <input type="checkbox"/>	Changed residence <input type="checkbox"/> Legal difficulties, multiple traffic tickets <input type="checkbox"/> Owe money <input type="checkbox"/>