RE-OPEN AND THERAPY EVALUATION FORM, ADULT Today's Date:_____

Name: (First) (M.I.) (Last)	Birth date:	Age:
Marital Status:	Gender Male Female	
In Case of Emergency, please contact:	Phone:	Relationship:

Brief description of the type of problem you are seeking help for_____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless – moving around a lot	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

For items 1-9, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ *Not difficult at all*
- ☐ *Somewhat difficult*
- ☐ *Very difficult*
- ☐ *Extremely difficult*

For items 1-9, when did you first notice these problems? _____

Please check the boxes ☒ of all other problems that you've had during *this last month*. Then, on the line that follows each problem tell us when you first noticed these problems.

- ☐ 10. Worrying and feeling nervous much of the time_____
- ☐ 11. Fears of crowds or having to talk to people_____
- ☐ 12. Feeling panic, heart pounding, feel like I'm losing it, I can't stand it_____
- ☐ 13. Can't get to sleep, or stay asleep_____
- ☐ 14. Sudden horrible memories or bad nightmares_____
- ☐ 15. Feeling that I have to do or think something over and over_____
- ☐ 16. Worrying a lot about germs, diseases, my health_____
- ☐ 17. Easily irritated and angry _____
- ☐ 18. Wanting to get revenge or hurt other people_____
- ☐ 19. Thoughts racing faster than I can follow them_____
- ☐ 20. Very extreme happiness or ambition_____
- ☐ 21. Hearing voices in my head or other strange experiences_____
- ☐ 22. Feeling like people are following me, monitoring me, or plotting to hurt me somehow_____
- ☐ 23. Out of control spending or gambling_____
- ☐ 24. Using drugs or drinking too much_____
- ☐ 25. Out of control eating_____
- ☐ 26. Dieting too much, or using laxatives or vomiting to lose weight_____
- ☐ 27. Concerns about sex_____
- ☐ 28. Frequent headaches, loss of balance, numbness, or sudden vomiting (circle which ones) _____
- ☐ 29. Frequent, constant, and/or extreme pain_____
- ☐ 30. Other problems:_____

CHEMICAL USE

Do you use tobacco products?	Yes	No	If yes, type_____ quantity per day _____
Do you drink caffeine?	Yes	No	If yes, type _____quantity per day_____
Have you drank alcohol in the past year?	Yes	No	If yes, usual number of drinks per day_____ Usual number of drinks per week_____

Please indicate any substances that you have used in the past year.

Cannabis- (Marijuana, Hashish)	yes	no	How often, how much?
Amphetamines- (Speed, Cocaine, Crack, Crank, Meth, Dexedrine, White Crosses, Ritalin, Cylert, etc.)	yes	no	How often, how much?
Tranquilizers- (Valium, Xanax, Ativan Librium, Sleeping Pills, Seconal, Quaaludes, etc.)	yes	no	How often, how much?
Narcotics- (Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.)	yes	no	How often, how much?
Other- Inhalants, PCP, LSD Mushrooms, Paint Thinner, Glue Nitrite "Poppers", etc.	yes	no	How often, how much?

Have you *ever* felt you ought to cut down on your drinking or drug use?	Yes	No
Have you ever had people annoy you by criticizing your drinking or drug use?	Yes	No
Have you ever felt bad or guilty about your drinking or drug use?	Yes	No
Have you ever had to drink or use drugs as an "eye opener" first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?	Yes	No

Please complete this section if it has more than 6 months since your last appointment at BHSI.

TREATMENT UPDATE List any psychological, psychiatric, and/or substance abuse treatment you have had since you were last here, including hospitalizations_____

_____

MEDICAL UPDATE

Primary Care Clinic: _____ Physician: _____

Describe any current medical conditions: _____

List current medications: _____

List drug allergies: _____

FAMILY UPDATE Please list changes in your family since you were last here _____

_____

_____

EDUCATION AND WORK UPDATE

List any changes in your work or education since you were last here_____

_____