

# CHRISTIAN COUNSELING ASSOCIATES

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Edmond, Oklahoma 73013  
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## COMPREHENSIVE ADULT PSYCHOSOCIAL/TREATMENT PLAN CONFIDENTIAL

NAME \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

PHONE \_\_\_\_\_

### CURRENT LIVING SITUATION

Describe your living arrangements (check all that apply)

- living with spouse/partner     living with biological family     living alone     living with relatives  
 adoptive family     living with friends     foster family     own/rent private residence  
 residential care home     institutional setting     community shelter or homeless

Children Living at home:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Children Living Outside of Home:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Yes  No Do you have problems with your children? Describe \_\_\_\_\_

Please list other individuals living in your home with you, including any who visit regularly

Name	Age	Relationship to you

### PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? \_\_\_\_\_

Please write a couple of sentences concerning the reason for your request of services.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe Your Partner** (check all that apply)

warm     abusive     tense     unhappy     critical     distant     perfect  
 affectionate     boring     caring     dependent     happy     indifferent     violent  
 alcohol/drug/dependent    behavioral addiction \_\_\_\_\_

other \_\_\_\_\_

**Is There Violence In The Home?**     No     Yes

Type:     mental     physical     emotional or verbal     spiritual

**Do you have any of the following problems with your partner?**

difficulty w/or conflict over sex     jealousy     abuse     affairs     conflict over employment  
 conflict over children     conflict over money     conflict over power  
 conflict over substance or behavioral addictions     relationship w/partner is satisfactory  
 have no current partner

If so, are you concerned about lacking a significant relationship     Yes     No

Additional comments \_\_\_\_\_

**Ethnic Group**     Caucasian     Black     Alaskan Native     Asian/Pacific Islander

American Indian, tribe \_\_\_\_\_     Hispanic \_\_\_\_\_     Other \_\_\_\_\_

**Cultural Information** *check all descriptions that apply regarding who or what life events have had the most influence on you*

holidays     chaotic family     violence     trauma     disabilities     addictions  
 spirituality/religion     family traditions     family culture     friends     neighbors     abuse  
 learning/education     school     sports     work     social     scouting  
 lifestyle choices     travel     reading     gender     social status     foods  
 nontraditional roles or experiences     community organizations

other *describe* \_\_\_\_\_

Note the relationship(s) of those people who were instrumental in influencing your life either positively (+) or negatively (-) (mother, father, sibling, grandparent, aunt/uncle, stepparent, cousin, friend, etc.) \_\_\_\_\_

**Check the problems for which you are seeking help** *check all that apply*

crisis     trauma     child's behavior     school     family issue     work     isolated  
 anger     stress     medical     grief/loss     conflict     DHS     divorce     step family  
 court     DUI     EAP referral     parenting     impulsive behaviors     bullying     marital  
 sibling issues     abuse     parent/child     communication     social skills     boundaries  
 problem solving skills     difficulty making/keeping friends     pre-marital     sexual conflict/guilt  
 problems w/sexual partner     overwhelming emotions     sexual identity conflict     rape/sexual assault

other *describe* \_\_\_\_\_

Describe how long this has been a problem \_\_\_\_\_

Tell how you have already tried to solve the problem \_\_\_\_\_

	Low					High				
How serious is this problem for you? ( <i>please circle</i> )	1	2	3	4	5	6	7	8	9	10
How hopeful are you that your life can be better?	1	2	3	4	5	6	7	8	9	10

Describe how you want your life to be different as a result of counseling \_\_\_\_\_

How long do you think it will take to resolve the problem(s) \_\_\_ 1-3 visits \_\_\_ 2-3 months \_\_\_ 6 months \_\_\_ other

Additional comments: Please include significant losses or events in your life (including experiences with pets).

Describe your strengths or the things you do well \_\_\_\_\_

What or who do you rely on for help or name the important relationships in your life:

\_\_\_ faith \_\_\_ family \_\_\_ friends \_\_\_ co-workers \_\_\_ neighbors \_\_\_ other

*describe* \_\_\_\_\_

Describe what you do for recreation or fun/leisure (include the type of activity and the frequency)

**Affect/Mood—Describe your experience** (*check all that apply*)

\_\_\_ mood swings \_\_\_ depression \_\_\_ grief \_\_\_ anger \_\_\_ numbness \_\_\_ sadness \_\_\_ anxiety/anxiousness  
\_\_\_ low energy \_\_\_ don't care about anything \_\_\_ euphoria \_\_\_ overwhelmed \_\_\_ unable to cope with emotions  
\_\_\_ change in appetite/sleep patterns \_\_\_ thoughts of hurting myself or someone else

Additional comments \_\_\_\_\_

**Thinking/Mental Process—Describe your experience** (*check all that apply*)

\_\_\_ oriented to person, time, place \_\_\_ memory problems (\_\_\_ short term \_\_\_ long term) \_\_\_ impulse control  
\_\_\_ ideas of guilt \_\_\_ difficulty concentrating \_\_\_ obsessive behaviors \_\_\_ disturbing nightmares/dreams  
\_\_\_ difficulty making decisions \_\_\_ dissatisfied with decisions made \_\_\_ feel persecuted/picked on  
\_\_\_ feelings of being unreal \_\_\_ suspicious of people/low trust \_\_\_ negative beliefs about yourself  
\_\_\_ ideas of hopelessness \_\_\_ ideas of worthlessness \_\_\_ preoccupied with sex \_\_\_ ideas of loss (hopes/dreams)  
\_\_\_ other people cause my problems \_\_\_ can't shut down thoughts \_\_\_ follow my faith even when it causes problems  
Delusions/hallucination \_\_\_ auditory \_\_\_ visual \_\_\_ delusions \_\_\_\_\_

Additional comments \_\_\_\_\_

**Educational/Occupational/History**

\_\_\_Yes \_\_\_No Are you the primary person responsible for home management?

Attitude toward school: \_\_\_liked it \_\_\_indifferent \_\_\_disliked it

Grades were primarily\_\_\_\_\_ If in school now, where?\_\_\_\_\_

\_\_\_Yes \_\_\_No Have you ever served in the military?

\_\_\_Yes \_\_\_No Experienced war?

\_\_\_Yes \_\_\_No Do you have a service connected disability? Describe\_\_\_\_\_

How do you support yourself? \_\_\_employment \_\_\_social security \_\_\_disability \_\_\_government assistance  
\_\_\_help from others \_\_\_other\_\_\_\_\_

What is your feeling/attitude towards your job? \_\_\_like it \_\_\_indifferent \_\_\_dislike it

\_\_\_Yes \_\_\_No Problems on the job? Explain\_\_\_\_\_

\_\_\_Yes \_\_\_No Have you ever been fired/laid off?

\_\_\_Yes \_\_\_No Medical reason you cannot work?

Describe:\_\_\_\_\_

Do you consider yourself \_\_\_effective \_\_\_impaired \_\_\_ineffective in the roles identified above?

**Personal History**

Describe any physical or emotional problems, of which you are aware, during your childhood:\_\_\_\_\_

Your primary caregivers during childhood were: \_\_\_birth parents \_\_\_mother only \_\_\_father only  
\_\_\_father & stepmother \_\_\_mother & stepfather \_\_\_adoptive parents \_\_\_foster parents \_\_\_grandparents  
other\_\_\_\_\_

Place/location of birth\_\_\_\_\_

Names/ages of siblings\_\_\_\_\_

\_\_\_Yes \_\_\_No Do you have any difficulty remembering or describing your childhood?

\_\_\_Yes \_\_\_No Did your parents argue frequently?

\_\_\_Yes \_\_\_No If yes, was any physical violence involved?

\_\_\_Yes \_\_\_No Are your parents divorced?

\_\_\_Yes \_\_\_No Were you physically abused? If Yes, by whom?\_\_\_\_\_

\_\_\_Yes \_\_\_No Did the family in which you grew up experience severe financial problems?

\_\_\_Yes \_\_\_No Has any inappropriate sexual behavior ever taken place around you or directed toward you?

If yes, by whom?\_\_\_\_\_ (name & relationship) Your age\_\_\_\_\_

Additional Comments\_\_\_\_\_

**Describe yourself as a child (C) or adolescent (A): check all that apply**

C\_\_\_ A\_\_\_ Outgoing C\_\_\_ A\_\_\_ Rebellious C\_\_\_ A\_\_\_ Popular C\_\_\_ A\_\_\_ Awkward

C\_\_\_ A\_\_\_ Unhappy C\_\_\_ A\_\_\_ Quiet C\_\_\_ A\_\_\_ Serious C\_\_\_ A\_\_\_ Happy

C\_\_\_ A\_\_\_ Aggressive C\_\_\_ A\_\_\_ Temperamental C\_\_\_ A\_\_\_ Calm C\_\_\_ A\_\_\_ Unpopular

C\_\_\_ A\_\_\_ Nervous C\_\_\_ A\_\_\_ Angry C\_\_\_ A\_\_\_ Thoughts of Suicide

Other\_\_\_\_\_ Things changed when I reached age \_\_\_\_\_

Because\_\_\_\_\_

**Check the following you experienced as a child (C) and/or adolescent (A):** *check all that apply*

- |                                 |                                   |                                |
|---------------------------------|-----------------------------------|--------------------------------|
| C___ A___ conflict w/mother     | C___ A___ conflict w/father       | C___ A___ conflict w/siblings  |
| C___ A___ conflict w/stepmother | C___ A___ conflict w/stepfather   | C___ A___ conflict w/peers     |
| C___ A___ targeted by bully     | C___ A___ conflict w/teachers     | C___ A___ conflict w/police    |
| C___ A___ conflict w/neighbors  | C___ A___ conflict w/stepsiblings | C___ A___ overweight           |
| C___ A___ anorexic/bulimic      | C___ A___ nightmares              | C___ A___ excessive fear/worry |
| C___ A___ drug/alcohol use      | C___ A___ bedwetting              | C___ A___ fire starting        |
| C___ A___ arrests/delinquency   | C___ A___ cruelty to animals      | C___ A___ attempted suicide    |
| C___ A___ sexual problems       | C___ A___ teen parent             |                                |
- Other \_\_\_\_\_

**Describe your caregivers: mother (M), father (F), stepmother (SM), Stepfather (SF), Other Caregiver (OC)**

*(check all that apply)*

	M	F	SM	SF	OC		M	F	SM	SF	OC
Warm	___	___	___	___	___	Overprotective	___	___	___	___	___
Domineering	___	___	___	___	___	Affectionate	___	___	___	___	___
Uncaring	___	___	___	___	___	Fault-Finding	___	___	___	___	___
Average	___	___	___	___	___	Strict	___	___	___	___	___
Smothering	___	___	___	___	___	Absent	___	___	___	___	___
Understanding	___	___	___	___	___	Rejecting	___	___	___	___	___
Distant	___	___	___	___	___	Perfect	___	___	___	___	___
Supportive	___	___	___	___	___	Too Little Discipline	___	___	___	___	___
Alcohol/Drug Use	___	___	___	___	___	Behavioral Addiction	___	___	___	___	___
Depressed/Unhappy	___	___	___	___	___						

**Legal Issues**

- |  |   |
|--|---|
| Do you have any legal issues pending? ___Yes ___No | Are you on probation or parole? ___Yes ___No    |
| Do you have a legal/criminal record? ___Yes ___No  | Ever been arrested as an adult? ___Yes ___No    |
| Have you ever been incarcerated? ___Yes ___No      | Any current DHS/Court involvement? ___Yes ___No |
- If yes to any of the above, please describe \_\_\_\_\_

**Conflict/Violence/Trauma Issues**

- Ever been threatened/attacked/afraid for safety/life? \_\_\_Yes \_\_\_No
- Experienced intimidation/control? \_\_\_Yes \_\_\_No
- Grew up in a home with chronic problems? \_\_\_Yes \_\_\_No
- Been a target of gender violence? \_\_\_Yes \_\_\_No
- Been a target of racism/discrimination? \_\_\_Yes \_\_\_No
- Been a target of bully at school or work? \_\_\_Yes \_\_\_No
- Additional Comments \_\_\_\_\_

**Substance/Behavioral Addiction History**

Yes  No My family has a history of addictions

If yes, who?  grandfather  grandmother  father  mother  sibling  other relatives

Yes  No I am concerned about my partner's use of substances/behaviors

Yes  No I am concerned about my child's use of substances/behaviors

Please indicate the impact addictions have on your life, relationships, work, etc. \_\_\_\_\_

I have a history of using/abusing the following:

Substance or Behavior	What and/or how Much	Age of 1 <sup>st</sup> use	Age of last use or still using	Oral, nasal, smoking, injection, other	Treatment or 12 step or group
Alcohol					
Drugs					
Prescription meds					
Tobacco					
Caffeine, teas, sodas					
Gambling					
Excessive Computer use					
*Sex					
**Codependency					
***Food issues					

\*Sex includes pornography, several partners, etc.

\*\*Codependency (focusing on others' behaviors, generally putting others first, feeling used & taken for granted)

\*\*\*Food includes excessive sugar, salt, junk foods, overweight, anorexia, bulimia

**MEDICAL**

Yes  No Are you **currently** under the care of a physician for medical problems? (your physician will not be contacted without your permission)

If yes, describe: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Yes  No Are you **currently** taking medications?

If yes, list those you are **currently** taking (use back of page if needed).

Medication	Strength/Dosage	Length Taken	Purpose & Side Effects

Please list any allergies: \_\_\_\_\_

In your opinion what is your current level of health? \_\_\_excellent \_\_\_good \_\_\_fair \_\_\_poor

In your opinion are you \_\_\_underweight \_\_\_appropriate weight \_\_\_overweight how many pounds \_\_\_\_\_

**Do you now or have you ever had:**

- \_\_\_ Yes \_\_\_ No Hearing problems
- \_\_\_ Yes \_\_\_ No Severe headaches
- \_\_\_ Yes \_\_\_ No Unable to move part of your body
- \_\_\_ Yes \_\_\_ No Goiter, thyroid problem
- \_\_\_ Yes \_\_\_ No Pains in your chest
- \_\_\_ Yes \_\_\_ No Abnormal thirst or hunger
- \_\_\_ Yes \_\_\_ No Hands, feet, ankle swelling
- \_\_\_ Yes \_\_\_ No Stomach trouble, ulcers
- \_\_\_ Yes \_\_\_ No Kidney trouble
- \_\_\_ Yes \_\_\_ No Sleeping problems
- \_\_\_ Yes \_\_\_ No Decreased interest in sex
- \_\_\_ Yes \_\_\_ No Liver disease, yellow skin/eyes
- \_\_\_ Yes \_\_\_ No Constipation/diarrhea
- \_\_\_ Yes \_\_\_ No Fainting spells/falling/dizzy
- \_\_\_ Yes \_\_\_ No Eye problems
- \_\_\_ Yes \_\_\_ No Change in appetite
- \_\_\_ Yes \_\_\_ No Surgeries Dates/Types: \_\_\_\_\_

**Check any that apply to you now or in the past:**

- \_\_\_ measles
  - \_\_\_ polio
  - \_\_\_ German measles
  - \_\_\_ meningitis
  - \_\_\_ mumps
  - \_\_\_ diphtheria
  - \_\_\_ lupus
  - \_\_\_ high blood pressure
  - \_\_\_ pneumonia
  - \_\_\_ glaucoma
  - \_\_\_ rheumatic fever
  - \_\_\_ skin problems
  - \_\_\_ thyroid disease
  - \_\_\_ diabetes
  - \_\_\_ heart problems
  - \_\_\_ bleeding ulcers
  - \_\_\_ mononucleosis
  - \_\_\_ blood clots
  - \_\_\_ anemia
  - \_\_\_ epilepsy/seizures
  - \_\_\_ food poisoning
  - \_\_\_ hepatitis
  - \_\_\_ HIV positive
  - \_\_\_ frequent colds
  - \_\_\_ broken bones
  - \_\_\_ concussions
  - \_\_\_ dislocations
  - \_\_\_ wounds
  - \_\_\_ head injury
  - \_\_\_ cancer
  - \_\_\_ fatigue
  - \_\_\_ weakness
  - \_\_\_ chills
  - \_\_\_ night sweats
  - \_\_\_ sexually transmitted disease
  - \_\_\_ enlarged prostate
  - \_\_\_ impotence
  - \_\_\_ menstrual problems
  - \_\_\_ still having period
  - \_\_\_ age at first period
  - \_\_\_ hormone replacement
  - \_\_\_ mood difficulty during menstrual cycle
- Pregnancy history: Total # of pregnancies \_\_\_ # of premature births \_\_\_ # of C-sections \_\_\_  
# of stillbirths \_\_\_ # of miscarriages \_\_\_ # of surgical abortions \_\_\_

**Does anyone in your family experience:**

- \_\_\_ depression \_\_\_ bipolar \_\_\_ schizophrenia **If yes, who?** \_\_\_ mother \_\_\_ father \_\_\_ sibling
- \_\_\_ Yes \_\_\_ No Are you **currently** receiving behavioral/mental health services elsewhere?

If yes, please provide the following:

Date	Type*	Where	Purpose/Diagnosis

\* out-patient, in-patient, crisis intervention, day treatment, group, etc.

