

SAP Personal History/Psychosocial Evaluation Form—Adult

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Please complete all items on this form and return to Dr. Garlock.

Thank You!

Client's name: _____ **Date:** _____

Gender: ___ F ___ M **Date of birth:** _____ **Age:** _____

Form completed by (if someone other than client): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone (home): _____ **(work):** _____ **ext:** _____

Who referred you for our services today? Please list their name, address and phone #

If more space is needed for any of your answers, please use the space on the last page of this form.

Primary reason(s) for seeking services: (Check all that are applicable in your situation)

___ Positive alcohol/drug test at work (specify): _____

___ Self referral due to your having an alcohol and/or drug problem you want help with

___ Supervisor or boss told you to get this evaluation completed without a positive alcohol or drug test having been performed

___ Other reason(s). Please explain: _____

Your Present Need And Expectations For Services

Please list in your own words why you are seeking Dr. Garlock's services today?

Did you have a positive Urine/Drug/Screen or Breathalyzer Test at work? ___ Yes

___ No If so, please list the date of the test, type of test, test outcome and the reasons for your positive alcohol and/or drug test at work:

Did you have an accident at work that led to your being tested for alcohol and/or drugs?

_____ **Yes** _____ **No** **If the answer is Yes, please explain what happened at work:**

Are you willing to attend either recommended services in order to complete the DOT requirements for you to return to work? _____ **Yes _____ **No** **If not, explain below:****

What outcome would you like to happen today with regard to your alcohol/drug related work problems due to your positive test or self referral?

If a miracle happened and the concerns or problems that you are seeking assistance for were resolved, what positive differences in behavior or situation or personal experiences would you expect to see occurring?

How will you know if the services that are recommended for you are successful?

Do you want to get sober and stay sober? _____ **Yes _____ **No** **If not, why?****

Are you willing to follow all of the recommendations given to you by Dr. Garlock and your recommended service provider? _____ **Yes _____ **No** **If no, why not?****

Family History Information/Evaluation

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___

Marital Status (more than one answer may apply)

Single _____ Divorce in process _____ Unmarried, living together _____ Length of time: _____
 Legally married _____ Separated _____ Divorced _____
 Length of time: _____ Length of time: _____ Length of time: _____
 Widowed _____ Annulment _____
 Length of time: _____ Total number of marriages: _____
 Assessment of current relationship (if applicable): _____ Good Fair Poor

Parental History Information/Evaluation

Parents legally married Mother remarried: Number of times: _____
 Parents have even been separated Father remarried: _____ Number of times: _____
 Parents ever divorced _____ Parent(s) deceased

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

How many moves did you make with your family as a child? _____ Did moving create problems for you as a child or adolescent? Yes No Did parental illness create problems for you as a child? _____ Yes _____ No Did parental substance abuse create problems for you as a child or as an adolescent? Yes No

Personal Developmental History Information/Evaluation

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If Yes, please describe: _____

Has there been history of child abuse? Yes No Child Neglect? Yes No

If Yes, which type(s)? Sexual Physical Verbal Emotional

If Yes, the abuse was as a: Victim Perpetrator

Other childhood issues: Neglect Inadequate nutrition Other (please specify): _____

Comments re: childhood development:

Social Relationships History/Evaluation

Check how you generally get along with other people: (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower

Friendly Leader Outgoing Shy/withdrawn Submissive

Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? Yes No

If Yes, describe: _____

Cultural/Ethnic Issues Evaluation

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious Evaluation

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

If Yes, describe: _____

Legal Evaluation

Current Status

Are you involved in any active cases (traffic, civil, criminal)? _____ Yes _____ No
If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? _____ Yes _____ No
If Yes, please describe: _____

Past History

Traffic violations: _____ Yes _____ No DWI, DUI, etc.: _____ Yes _____ No
Criminal involvement: _____ Yes _____ No Civil involvement: _____ Yes _____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Educational Evaluation

Fill in all that apply: Years of education: _____ Currently enrolled in school? _____ Yes _ No
___ High school grad/GED _____ List grade you stopped attending school in: _____
___ Vocational: Number of years: __ Graduated: __ Yes _____ No ___ Major: _____
___ College: Number of years: __ Graduated: __ Yes ___ No Major: _____
___ Graduate: Number of years: __ Graduated: __ Yes ___ No Major: _____
Other training: _____ Special circumstances (e.g., learning disabilities, AD/HD, gifted): _____

Employment Evaluation

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: _____ FT _____ PT _____ Temp _____ Laid-off _____ Disabled _____ Retired
___ Social Security _____ Student Other (describe): _____
How many hours do you work a week? _____ 20 _____ 30 _____ 40 _____ 50 _____ 50+
Has anyone told you that they think that you work too much? _____ Yes _____ No If yes, who told you that you work too much? _____
Are you a workaholic? _____ Yes _____ No If yes, why do you think so? _____

Military Evaluation

Military experience? _____ Yes _____ No Combat experience? _____ Yes _____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational Evaluation

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____

Do you visit the internet? ____ Yes ____ No If yes, how much time do you spend on the internet daily and during an average week? _____ Daily time _____ Weekly time Do you think that you may have an internet overuse problem? ____ Yes ____ No Has anyone told you that they think that you may have an internet use/abuse problem? ____ Yes ____ No If yes, do you believe them or not? ____ Yes ____ No If yes, please explain: _____

Medical/Physical Health Evaluation

Please check the symptoms that you are presently having or being treated for:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Abortion	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Sexually related diseases
<input type="checkbox"/> Allergies	<input type="checkbox"/> Eating problems	<input type="checkbox"/> Sleeping disorders
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Small Pox
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Measles	<input type="checkbox"/> Toothache
<input type="checkbox"/> Colds/Coughs	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Constipation	<input type="checkbox"/> Mumps	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Dental problems	<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurological disorders	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nausea	_____

List any current health concerns: _____

List any recent health or physical changes: _____

Nutritional Evaluation

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High
Comments: _____						

Current Medications Taken

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? _____ Yes ___ No Do you abuse prescription drugs? _____ Yes _____ No What do you abuse? _____

If Yes, describe: _____

Medical Information/History/Evaluation

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _

Please check if there have been any recent changes in the following:

Sleep patterns Eating patterns Behavior Energy level
 Physical activity level General disposition Weight
 Nervousness/tension Moods Vision/Hearing

Describe changes in areas in which you checked above: _____

Tobacco And Caeffine Use History/Evaluation

Do you use tobacco? Yes No If yes, how much do you use daily? _____
 How many cigarettes and cigars do you smoke a week? _____
 How long have you been smoking? _____ Years _____ Months
 What brand do you smoke? _____
 Do you have any health problems related or due to smoking? Yes No
 Are you being treated for illnesses related to your tobacco use? Yes No What are
 You being treated for? _____
 Have you tried to quit smoking? Yes No When did you try to quit smoking? _____

Do you use caeffine? Yes No If yes, what do you use? _____
 How many soft drinks do you drink a day? _____
 How many cups of coffee or tea do you drink daily? _____

Chemical Use History/Evaluation

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	_____

Substance(s) of preference that you like to use now

1. _____ 3. _____
 2. _____ 4. _____

Substance Abuse Questions/Evaluation

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use)

Reason(s) for use:

Addicted Build confidence Escape Self-medication
 Socialization Taste Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? Yes _____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? Yes No

If Yes, describe: _____

Do you think you have an alcohol or drug use/abuse problem? _____ Yes _____ No If yes,
please describe the problem: _____

Counseling/Prior Treatment History/Evaluation

Information about client's treatment history (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon,	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Who	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how these symptoms impair your ability to function effectively:

What meaning do your symptoms have for you in terms of your daily living and need meeting?

Any additional information that would assist us in understanding your concerns or problems: __

What are your goals for services? _____

How will you know if your goals for service delivery have been met?

Do you feel suicidal at this time? _____

No _____

Yes _____

Other Information That You Would Like Dr. Garlock To Know About You:

Psychosocial Signature Section

By signing this form, I certify and attest that I have been honest in my responses and that all information contained in this interview questionnaire is accurate and honest. I certify and attest that I have not withheld any information regarding my substance use history, my legal involvement history, my work history or any other factor that could influence the outcome of this evaluation process.

Client's signature _____ **Date:** ___/___/___

Psychosocial Evaluator _____ **Date:** ___/___/___

Psychosocial Evaluation Rating Of Validity Of Psychosocial History Information

_____ **Valid** _____ **Partially Valid** _____ **Not Valid** **If not valid, why not?**
