

FUNCTIONAL ASSESSMENT TOOL

The purpose of this questionnaire is to help Dr. Larsen learn more about you or your child. By completing these questions as fully and as accurately as you can, you will ensure that Dr. Larsen has the information he needs about you or your child. If the patient is a child or dependent, please complete the form with information relevant to that person.

General Information

Date: _____

Name:				
Age:	Date of Birth		Gender (circle one):	M F
Address:				
City:		State:	Zip code:	
Telephone Numbers	(days):		(evenings):	
Occupation:	Who referred you?			
Marital Status (circle one):	Single	Married	Separated	Divorced
Emergency Contact:		Relation:	Phone:	

Information about your Concern or Problem

1. Please describe the primary concern for which you have come to our offices
1a. Is your problem today related to a military deployment? Yes / No / Maybe
2. How long have you been experiencing this concern?
3. Please describe any significant events occurring since then, which may relate to the concern(s):
4. What led to your decision to address this concern now? (What's different today?)
5. Have you had difficulties or issues like this before (Yes / No) Please Describe:

6. What solutions to your concerns have you tried?

Stressors

7. Is there anything else, recent or long-standing, that has been very stressful for you? Yes / No (If yes, circle all that apply)
Financial , Work Related, Legal/Disciplinary, Physical Injury, Trauma/Abuse, Family/Interpersonal, Educational.
Please Describe:

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Psychological Function

8. How would you describe your mood during the past week ? Depressed, Irritable, Anxious, Good, Other _____

9. Has your appetite changed?(Y / N); If yes:(Up , Down); Weight Change? (Up / Down _____Lb.)

10. Have you noticed a change in your sleep pattern? (Yes / No) If yes, how much more ___ or less___

11. Have you noticed a change in your normal amount of energy? (Yes / No) (more, less?)

12. Have you recently lost interest in pleasurable activities? (Yes / No)

13. Are you feeling at the present time helpless or hopeless? (Yes / No)

14. Do you find it difficult to concentrate? (Yes / No)

15. Have you had any problems functioning normally at your job/at home/socially? (Yes / No) Please describe:

16. Have you recently engaged in any dangerous or impulsive activities? (Yes / No) Please explain:

17. Do you have any repetitive thoughts that don't seem to stop? (Yes / No) If Yes, what are the thoughts?

18. Do your thoughts seem to be going so fast that you can't keep up with them? (Yes / No)

19. Have you in the last 3 days had thoughts that don't make sense or seem unreal? (Yes / No) If Yes, please describe

20. Do you see, hear, feel or smell things that other people do not? (Yes / No)

21. Do you feel others are against you, trying to harm you or control you? (Yes / No)

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Substance Use: (Alcohol)

22. On average how much do you usually drink? Consider all beverage forms of alcohol (wine, beer, liquor) & circle one below:

Don't Drink Less than 1-2 drinks a day 1-2 drinks a day 3-6 drinks a day 7 or more drinks a day

If you do not drink and you've never had a problem with drinking, please skip to item 34. If you do drink or have ever had a problem with drinking, please continue with the next item.

23. When was the last time you drank and how much?

24. Has there been an increase in the amount of your drinking during the past six months? (Yes / No)

25. Have you recently cut back or felt you should? (Yes / No)

26. Have you recently felt annoyed by people criticizing your drinking? (Yes / No)

27. Have you recently felt guilty or bad about your drinking? (Yes / No)

28. Have you ever taken a drink to relieve a hangover or calm your nerves? (Yes / No) *(for example, morning drinking)*

If you answered "yes" to any of the last four questions (items 25-28), continue with remaining questions. If all answers were "no", go to item 34.

29. Have you recently had problems (work/social/legal) because of your drinking? (Yes / No) Circle all that apply.

30. Have you recently experienced medical problems from your drinking? (Yes / No) (e.g., stomach, high blood pressure, accidents, injuries, liver problems?)

31. Have you recently been unable to remember events that occurred while you were drinking? (i.e., blackouts) (Yes / No)

32. Have you recently been treated in an alcohol treatment program and then returned to drinking? (Last 24 months) (Yes / No)

33. Have you ever experienced shakes or tremors, seizures, hallucinations, increased sweating, insomnia, racing heart, increased irritability or restlessness when you tried to stop or decrease the amount of drinking? (Yes / No) *(If 'Yes' circle all of the underlined symptoms that apply.)* Do you currently have any of the above symptoms? Yes / No.

Substance Use (Drugs)

34. Do you use any illicit or street drugs? (Yes / No) If yes, circle the ones used:

Cannabinoids (marijuana, hashish)	Crack/Cocaine	Inhalants (glue, paint, aerosol cans)
Opiates (heroin)	PCP, LSD	Amphetamines (uppers)
Steroids	Other: _____	

35. Do you use prescription medications in ways not prescribed for you? (Yes / No) Please Describe: *(Names of Medications, Amount, Frequency)*

If the answers to questions 34 & 35 are "no", go to item 46, if one or both are "yes", please continue with the next items.

36. How often do you use drugs? Daily/Weekly

37. When did you last use drugs? How much did you use that time?

38. Has there been an increase in your drug use during the past six months? (Yes / No)

39. Has your drug use caused any problems at work, at home, at school, or with the law? (Yes / No) *(circle all that apply)*

40. Have you recently had any physical problems related to your drug use? (Yes / No) (If yes, list problems)

41. Have you recently been treated for drug use and then returned to using drugs? (Yes / No)

42. Have you ever been hospitalized for drug withdrawal and/or treatment? (Yes / No)

43. What's the longest you have gone in the last 12 months without using drugs? (< Day, < Week, <Month, >Month)

44. Do you engage in risky behaviors to support your use of drugs? (Yes / No) Please describe:

45. Are you currently experiencing any signs of withdrawal? (Yes / No)

Risk of Harm to Self or Others

46. Have you gotten so distressed about your current situation that you wish you would not wake-up or not be around anymore? (Yes / No)

47. Has your situation made you so distressed that you wish you could end your own life? (Yes / No) (*If **NO** skip to # 60*)

48. Are you thinking about hurting yourself right now? (Yes / No)

49. Do you have a specific plan to hurt yourself? (Yes / No)

50. Have you done anything recently to hurt yourself? (Yes / No)

51. Do you engage in self injurious behaviors (scratching, cutting or burning yourself) to release pain or stress? (Yes / No)

52. Are you now hearing voices telling you to hurt or kill yourself? (Yes / No)

53. Have you heard voices telling you to hurt yourself? (Yes / No)

54. If you have not hurt yourself, but have thought about it, what has stopped you?

55. Do you have access to any weapons/means to hurt yourself? (Yes / No) If yes, what kind?

56. Is your safety at risk if you are left alone? (Yes / No)

57. What are some ways that you could keep yourself safe in the next 24 hours?

58. Would you call someone before hurting yourself? (Yes / No)

59. Have you ever tried to hurt or kill yourself?(Yes / No) If yes, how so? _____

60. Has your current situation made you so distressed that you have thought about hurting or killing someone else? (Yes / No) (*If **NO** then go to # 67, if **YES** continue with the next item*)

61. Have you considered any particular person?(Yes / No) If "Yes", what is the persons name: _____
Where do they live / work? _____ What is their phone number? _____

62. Have you considered any particular ways or plans to hurt someone else? (Yes / No)

Please Explain:

63. Do you have access to means/weapons? (Yes / No)
If so, what kind?

64. If you were able to get help with your problems, would you still feel as though you would harm/kill others? (Yes / No)

65. If you are having thoughts about hurting others, what are some ways you can keep yourself from acting on those thoughts?

66. Do you currently hear voices telling you to hurt other people? (Yes / No)

67. Within the past six months, have you slapped, punched, pushed or kicked anyone (Yes / No) (Circle all that apply).

68. Have you ever hurt anyone (including spouse or children) or destroyed property because you could not control your anger ? (Yes / No) Please explain:

69. Have you ever been arrested for violent or abusive behavior?(Yes / No)

Quality of Life

71. Do you live alone ? (Yes / No)

72. Are things at home going all right? (Yes / No) If "No", please describe.

73. Are you geographically isolated from your family or friends? (Yes / No)

74. Is there anyone you can confide in? (Yes / No)

75. Have you recently experienced rejection by other people around you? (Yes / No)

76. Do you feel as though your relationships with family and friends are in a state of conflict? (Yes / No)

77. Have you recently withdrawn from friends and family and become isolated? (Yes / No)

78. Do you belong to any groups or organizations that are supportive and helpful to you? (Yes / No) If "Yes", please describe:

79. What do you like to do for leisure?

80. Is spirituality a source of support in your life?

81. Do your spiritual beliefs affect your current problems? Yes / No If yes, please describe how.

82. Is it important to you to have a counselor who shares your spiritual beliefs? Yes / No

Learning, Education, Occupation

83. Is English your primary language? (Yes / No) If "No", please explain

84. Do you have any difficulty reading or writing? (Yes / No) If "Yes", please explain.

85. How many years of education have you completed? _____ Degrees:

86. Are you experiencing problems with your current occupation (occupation means your role in life, as worker, student, home caretaker...) Yes / No If yes, please describe.

87. Are you facing legal problems or administrative/disciplinary actions? (Yes / No) If "Yes", please describe.

Family and Childhood History

88. Did you experience any problems or difficulties in your upbringing that may be impacting your current problems? (Yes / No) If "Yes", please describe.

89. Did you experience any traumatic events during your childhood that may be impacting your current problems? (Yes / No) If "Yes", please describe.

90. Do any of your blood relatives (your parents, siblings or children) suffer from alcoholism \ drug abuse or any other type of mental or emotional disorder? (Yes / NO) If "Yes", please fill out information below regarding each relative with disorder.

Relationship: _____ Type of Problem: _____ Treatment _____

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Treatment History

91. Have you received counseling or treatment for mental, emotional, alcohol or substance use problems in the past? (Yes / No) *(If **NO** then go to # 96, if **YES** continue with next item)*

92. In your previous mental health treatment, were you hospitalized? (Yes / No)

93. Were you prescribed medications? (*If yes, which medications?*)

94. Are you currently in treatment? (Yes / No) If yes, what is the name of the provider?)

95. Have you ever been prescribed medications for anxiety, sleeplessness, depression, unusual thoughts? (Yes / No) (*If yes, which medications?*)

Health/Medical Status and History

96. How is your health? (Excellent, Good, Fair, Poor) If fair or poor, please explain:

97. Have you had any serious illnesses or operations in the past year ?

98. Do you have any concerns about your eating or nutrition? Yes / No **(If yes, please describe)**

99. Would you like to learn more about proper nutrition? Yes / No

100. Do you have any concerns about your physical health and/or chronic health problems? Yes\ No **(If yes, please describe)**

101. Do you take any prescription medications? Please list:

102. Do you take any over-the-counter medications or herbal remedies? (e.g., ASA, sleep aids, diet pills, antacids, cough/cold/allergy) (Please describe, including amount and frequency of each medication):

103. Are you allergic to any medications? Yes / No

104. Are you in physical pain today or have you been in the recent past? Yes / No **(If NO go to the next page, if YES continue with next item)**

104a. Rate your pain using a 0-10 scale where 0 = no pain, 5 = medium pain, and 10 = the worst possible pain: _____

104b. Where is the pain?

104c. Is the pain constant or intermittent?

104d. Does the pain radiate? Yes / No

104e. Describe the pain: dull / sharp / throbbing / burning / etc.

104f. What are you doing to manage or reduce your pain?

104g. What makes the pain better?

104h. What makes the pain worse?

104i. What do you think is the cause of the pain?

Treatment Goals Checklist

In order to offer you the treatment opportunities most in line with your reasons for coming to this office, please read the goals below and **circle the number of each goal** in which you would like to see improvement:

Improving communication with _____

Better managing physical pain

Reducing family difficulties	Better managing my anger or temper
Improving my sleep	Receiving medication help
Controlling my drug / alcohol / tobacco use (circle any that apply)	Reducing thoughts of harm to self or others
Controlling my eating or weight	Military discharge or reassignment
Dealing with purging (vomiting, laxatives)	Better accepting a loss or death
Reducing fears/worries about _____	Learning how to relax
Improving my sexual relationship	Improving communication / assertiveness
Reducing my emotional reactions	Feeling less depressed or guilty
Other (describe):	

What strengths or resources do you have that will help you work on the goals you selected?

What barriers or problems may prevent you from making progress on the goals you've selected?

_____ Date _____
Patient Signature

Please stop here. Thank you for providing Dr. Larsen this information to better know your needs.