Presenting Issue

A Window of Hope Counseling Center/-
Harold W. Anderson LLC

324 E. Railroad Ave., #400, Ft., Morgan, CO 80701

Phone: 970-380-1160 | FAX: 970-205-9462 | Email: hwanderson@q.com
Visit our website at www.HaroldAnderson.net

Harold W. Anderson, Ph.D., LMFT, CAC III, AAMFT Approved Supervisor

Patient Code (office Only)

Date: (mm/dd/yyyy)

Patient Name

Birthday (mm/dd/yyyy)

Presenting Issue (why you are seeking help; describe symptoms, frequency, progression, and situations in which it is most present):

When did you first experience this issue?

If more than three months, why did you wait until now to seek therapy?

What do you hope to accomplish with therapy? Be as specific as you can

On a scale of 1 - 10, with 1 being no problem and 10 being maximal problem, how problematic is the presenting issue to your life?

	1	2	3	4	5	6	7	8	9	10
	○	○	○	○	○	○	○	○	○	○

What have you done to try and alleviate this problem? Have you been able to alleviate this problem in the past? How?

Stressors

Given the list of categories below, how much stress is each causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family	○	○	○	○
Friends	○	○	○	○
Relationships	○	○	○	○
Educational	○	○	○	○
Economic	○	○	○	○
Occupational	○	○	○	○
Housing	○	○	○	○
Legal	○	○	○	○
Health	○	○	○	○

How have these stressors affected your problem and how has the problem limited your ability to function in family life, relationships, work, friendships, etc. Explain in detail.

The following has to do with your alcohol and/or substance abuse.

How often do you have a drink of alcohol?

	Never (skip next 2 questions	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week
	○	○	○	○	○

How many drinks containing alcohol do you have on a typical day when you are drinking?

	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
	○	○	○	○	○

How often do you have six or more drinks containing alcohol on one occasion?

	Never	Less than monthly	Neutral	Monthly	Weekly	Daily or almost daily
	○	○	○	○	○	○

On a scale of 1 to 10 with 1 being no problem and 10 being maximal problem, how much of a problem is your drinking for your presenting problem?

	1	2	3	4	5	6	7	8	9	10
	○	○	○	○	○	○	○	○	○	○

Do you have a history of recreational drug use?

◯ YES

◯ NO

If YES, please fill out the table below to the best of your knowledge.

	Age of First Use	Age of last use?	How was it taken?	Amount per day	Days per week
Amphetamine/ Speed ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Barbiturates/ Downers ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		
Opiates ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

	Age of First Use	Age of last use?	How was it taken?	Amount per day	Days per week
Cocaine ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

	Age of First Use	Age of last use?	How was it taken?	Amount per day	Days per week
Psychedelics (e.g., Ecstasy, LSD, bath salts) ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

	Age of First Use	Age of last use?	How was it taken?	Amount per day	Days per week
Inhalants (e.g., glue, aerosols) ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

	Age of First Use	Age of last use?	How was it taken?	Amount per day	Days per week
Cannabis/ marijuana ◯ YES ◯ NO			☐ Oral ☐ Nasal ☐ Inhaled ☐ Injected		

Benzodiazepines

◯ YES
◯ NO

Age of First Use

Age of last use?

How was it taken?

☐ Oral
☐ Nasal
☐ Inhaled
☐ Injected

Amount per day

Days per week

PCP

◯ YES
◯ NO

Age of First Use

Age of last use?

How was it taken?

☐ Oral
☐ Nasal
☐ Inhaled
☐ Injected

Amount per day

Days per week

Caffeine

◯ YES
◯ NO

Age of First Use

Age of last use?

How was it taken?

☐ Oral
☐ Nasal
☐ Inhaled
☐ Injected

Amount per day

Days per week

Other

Age of First Use

Age of last use?

How was it taken?

☐ Oral
☐ Nasal
☐ Inhaled
☐ Injected

Amount per day

Days per week

On a scale of 1 to 10 with 1 being no problem and 10 being maximal problem, how has recreational drug use affected your presenting problem

	1	2	3	4	5	6	7	8	9	10
	○	○	○	○	○	○	○	○	○	○

Psycho-Social History

Level of education (check the one(s) that apply

- ☐ Less than high school
- ☐ GED
- ☐ High School
- ☐ Technical School
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate
- ☐ Post-doctoral work

Have you ever served in the Armed Forces?

- ○ YES
- ○ NO

If yes, does your military service affect your presenting problem

- ○ YES
- ○ NO

If YES, please explain:

Do you now or have you ever belonged to a group or social organization?

- ○ YES
- ○ NO

If yes, please list them below (one per line)

Do any of these groups or social organizations have an impact upon your presenting problem? Explain

Do you belong to a religious organization?

- ○ YES
- ○ NO

If YES, which religious organization?

Does your involvement in this religious organization impact your presenting problem? If so, explain below:

What is your ethnicity?

Do you think ethnic or cultural issues will impact your treatment?

- ◯ YES
- ◯ NO

What is your sexual orientation?

What is your gender identity?

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Gender Fluid

On a scale of 1 to 10, 1 being no affect and 10 being maximal affect, how does your sexual orientation and/or gender identity affect your presenting problem?

	1	2	3	4	5	6	7	8	9	10
	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Explain:

Psychotropic Medication History

Have you ever taken medication for a mental health issue

- ◯ YES
- ◯ NO

Are you presently taking medication for the issue described above?

- ◯ YES
- ◯ NO

If yes, list all medications you have taken/are taking below:

Medication Name: | Dose | How long? | End Date (approx)

Therapeutic effect | Side effects | Reason for stopping

Medication Name: | Dose | How long? | End Date (approx)

Therapeutic effect | Side effects | Reason for stopping

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Dose

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End Date (approx)

Therapeutic effect

Side effects

Reason for stopping

Medication Name:

Dose

How long?

End Date (approx)

Therapeutic effect

Side effects

Reason for stopping

Inpatient Psychiatric History

Do you have a history of inpatient psychiatric/mental health and/or behavioral treatment?

- ◯ YES
- ◯ NO

If yes, please fill out the requested information below.

Hospital/Facility

Voluntary

- ☐ YES
- ☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

- ☐ YES
- ☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

☐ YES

☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

☐ YES

☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

☐ YES

☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

☐ YES

☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

☐ YES

☐ NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Hospital/Facility

Voluntary

- [ ] YES
- [ ] NO

Primary reason for hospitalization

Age

Treatment Outcome

Additional Comments:

Outpatient Mental Health History

Do you have a history of outpatient psychiatric/mental health and/or behavioral treatment?

- ◯ YES
- ◯ NO

If yes, please fill out the requested information below.

Provider

Primary reason for hospitalization

Age of first

Age of last

Treatment Outcome

Additional Comments:

Provider

Primary reason for hospitalization

Age of first

Age of last

Treatment Outcome

Additional Comments:

Provider

Primary reason for hospitalization

Age of first

Age of last

Treatment Outcome

Additional Comments:

Provider

Primary reason for hospitalization

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Primary reason for hospitalization

Age of first

Age of last

Treatment Outcome

Additional Comments:

Provider

Primary reason for hospitalization

Age of first

Age of last

Treatment Outcome

Additional Comments:

Provider

Primary reason for hospitalization

Age of first

Age of last

Treatment Outcome

Additional Comments:

The information contained in this form is accurate to the best of my knowledge.

Signature

Date (mm\dd\yyyy)

Please return this form to the office at least 24 hours prior to your appointment or email it to hwanderson@q.com. Or, you may FAX it to 970-205-9462. If you choose to email it you can go to www.sendinc.com and mail it securely. You will need to set up an account, which is free. Thank you.