Kelly Bernstein, MS, LCDC, LPC
Alamo Heights Forensic and Individual Therapy
1600 North East Loop 410, Suite 112
San Antonio, Texas 78209
Office: (210) 265-1952 Fax: (210) 267-1653

Functional Assessment Tool

The purpose of this questionnaire is to help Kelly Bernstein, MS, LCDC, LPC learn more about you. By ***completing these questions as fully and as accurately as you can***, you will ensure that Kelly Bernstein, MS, LCDC, LPC has the information that she needs about you.

General Information

Date: _____

Name: _____

Age: _____ Date of Birth: _____ Gender (circle one) Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: (day) _____ (evening) _____

Occupation: _____ Who Referred You: _____

Marital Status (circle one): Single Married Separated Divorced Widow

Emergency Contact: _____ Relation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Information About Your Concern or Problem

1. Please describe the primary concern for which you have scheduled an appointment today.
_____
_____
_____

Is your problem or concern today related to a military deployment? YES NO

2. How long have you been experiencing this concern or problem? _____

3. Please describe any significant events occurring since then, which may relate to your concern or problem.
_____
_____

4. What led you to address this concern or problem now? (What is different today?) _____
_____
_____

5. Have you had difficulties or issues like this before (circle one)? YES NO
Please Describe: _____
_____

6. What solutions to your concern or problem 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, Legal/Disciplinary, Physical Injury, Trauma/Abuse, Family/Interpersonal.
Please Describe: _____
_____

Psychological Function

8. How would you describe your mood during the last week? depressed, irritable, anxious, other:_____

9. Has your appetite changed? (YES / NO) If YES: (UP /DOWN) Weight change? (UP/ DOWN _____Lb.)

10. Have you noticed a change in our 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) If YES, How much more_____ or 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 do not seem to stop? (YES/NO)
If YES, what are the thoughts? _____
_____
_____

18. Do your thoughts seem to be 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)

Substance Use: (Alcohol)

22. On average how much do you usually drink? Consider all beverage forms of alcohol (wine, beer liquor) and 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 or you have <u>never had a problem with drinking,</u> 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 that you drank and how much? _____

24. Has there been an increase in the amount of your drinking during the last 6 months? (YES/ NO)

25. Have you recently cutback or thought that 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 dink 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)

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

31. Have you recently been unable to remember events that occurred while you were drinking? (YES/ NO) (e.g., blackouts)

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

33. Have you experienced <u>shakes</u> or <u>tremors</u>, <u>seizures</u>, <u>hallucinations</u>, <u>increased sweating</u>, 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 listed 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 that are 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 6 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 been hospitalized for drug withdrawal and/ or treatment? (YES/ NO)

43. What is the longest that you have gone in the last 12 months without using drugs? _____

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) ***(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 you 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 person's name? _____

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 "YES", 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 6 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

70. Do you live alone? (YES/ NO)

71. Are things at home going all right? (YES/ NO) *If "NO", please explain:* _____
_____

72. Are you geographically isolated from your family or friends? (YES/ NO)

73. Is there anyone you can confide in? (YES/ NO)

74. Have you recently experienced rejection by other people round you? (YES/ NO)

75. Do you feel as though your relationships with family and friends are in a state of conflict? (YES/ NO)

76. Have you recently withdrawn from friends and family and become isolated? (YES/ NO)

77. Do you belong to any groups or organizations that are supportive and helpful to you? (YES/ NO)

78. What do you like to do for leisure? _____
_____

79. Is spirituality a source of support in your life? (YES/ NO)

80. Do your spiritual beliefs affect your current problems? (YES/ NO) *If "YES", please describe how:* _____
_____

81. Is it important to you to have a counselor who shares your spiritual beliefs? (YES/ NO)

Learning, Education, Occupation

82. Is English you primary language? (YES/ NO)

83. Do you have any difficulty reading or writing? (YES/ NO)

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

85. 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:* _____
_____

86. Are you facing legal problems or administrative/ disciplinary actions? (YES/ NO) *If "YES", Please explain:* _____
_____

Family and Childhood History

87. Did you experience any problems or difficulties in your upbringing that may be impacting your current problems? (YES/ NO)
If "YES", please explain: _____
_____

88. Did you experience any traumatic events during your childhood that may be impacting your current problems? (YES/ NO)
If "YES", please explain: __
_____

89. 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: _____
Relationship: _____ Type of Problem: _____ Treatment: _____
Relationship: _____ Type of Problem: _____ Treatment: _____
Relationship: _____ Type of Problem: _____ Treatment: _____
Relationship: _____ Type of Problem: _____ Treatment: _____

Treatment History

90. Have you received counseling or treatment for mental, emotional, alcohol or substance abuse use problems in the past? (YES/ NO) ***(If "NO", then go to #95, if "YES" continue with the next item)***

91. In your previous mental health treatment, were you hospitalized? (YES/ NO)

92. Were you prescribed medications? (YES/ NO) ***If "YES, which medications?***

_____ _____
_____ _____
_____ _____

93. Are you currently in treatment? (YES/ NO) ***If "YES", what is the name of the provider***? _____

94. Have you ***ever*** been prescribed medications for anxiety, sleeplessness, depression, unusual thoughts? (YES/ NO)
If "YES", which medications?

_____ _____
_____ _____
_____ _____

Please provide any additional information that you feel might helpful to Kelly Bernstein, MS, LCDC, LPC:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Health/ Medical Status and History

95. How is your health? (Excellent/ Good/ Fair, Poor) ***If "FAIR" or "POOR", please explain:*** _____
_____

96. Have you had any serious illnesses or operations this year? (YES/ NO) ***If "YES", please explain:*** _____
_____

97. Do you have any concerns about eating or proper nutrition? (YES/ NO)

98. Would you like to learn more about proper nutrition? (YES/ NO)

99. Do you have any concerns about your physical health and/ or chronic health problems? (YES/ NO) ***If "YES", please describe:***_____
_____

100. Do you take any prescription medications? (YES/ NO) **If "YES", please list:**

_____ _____
_____ _____
_____ _____

101. 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:***

_____ _____
_____ _____
_____ _____

102. Are you allergic to any medications? (YES/ NO) ***If "YES," please list:***

_____ _____

103. 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 the next item.***

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

b. Where is the pain?

c. Is the pain constant or intermittent?

d. Does the pain radiate? (YES/ NO)

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

f. What are you doing to reduce your pain? _____

g. What makes the pain better? _____

h. What makes the pain worse? _____

i. 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:

1. Improving communication with _____
2. Reducing family difficulty
3. Improving my sleep
4. Controlling my drug / alcohol/ tobacco use
   (circle all that apply)
5. Controlling my eating or weight
6. Dealing with purging (vomiting, laxatives)
7. Reducing fears/ worries about _____
8. Improving my sexual relationship
9. Reducing my emotional reactions
10. Better managing physical pain
11. Better managing my anger or temper
12. Receiving medication help
13. Reducing thoughts of harm to self or others
14. Military discharge or reassignment
15. Better accepting a loss or death
16. Learning how to relax
17. Improving communication / assertiveness
18. Feeling less depressed or guilty

Other (describe): _____
_____
_____

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

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

_____ _____
Client Signature Date

Please stop here. Thank you for providing Kelly Bernstein, MS, LCDC, LPC this information to better know our needs.