Blue Ridge Counseling

Joe Stapp, MA, LPC, NCC

Phone: 706-974-3899 ***joestapp@blueridgecounseling.org*** ***www.blueridgecounseling.org***

NAME: _____ **DATE: _____**

DATE OF BIRTH: _____ **PHONE: _____**

Why are you seeking counseling or treatment services at this time?

_____

_____

_____

_____

_____

_____

_____

Please list the problems, events, significant losses, or changes that create the most stress at the present time:

_____

_____

_____

_____

_____

_____

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CHECK ALL ITEMS BELOW THAT APPLY TO YOUR CURRENT SITUATION:

☐ Headaches	☐ Feel like crying	☐ Financial Problems
☐ Stomach problems	☐ Unable to have a good time	☐ Unemployment
☐ Bowel trouble	☐ Panicky feelings	☐ Job Problems
☐ Tremors or tics	☐ Sexual problems	☐ School problems
☐ Changes in appetite	☐ Put up a good front	☐ Loss of interest in things
☐ Eating problems	☐ Feel apart from other people	☐ Legal problems
☐ Weight change	☐ Irritable	☐ Temper problems
☐ Sleep problems	☐ Frightened, feel scared	☐ Feel worthless
☐ Nightmares	☐ Feel I will lose control	☐ Low self esteem
☐ Tired a lot	☐ Can't make decision(s)	☐ Misunderstood
☐ Too much energy	☐ Ready to explode	☐ Angry a lot

If you are currently employed, how satisfied are you with your job? Please check one:

☐ Very satisfied ☐ Moderately satisfied ☐ Satisfied ☐ Moderately dissatisfied

☐ Very dissatisfied

Please check all that apply: ☐ Vision Impairment ☐ Hearing Impairment ☐ SSI/Disabled

☐ Pregnant ☐ Veteran ☐ IV Drug User ☐ HIV+

How is your spiritual life right now? Please check one:

☐ In good shape ☐ Developing ☐ Very poor ☐ None or N/A

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How many changes would you like to make in yourself? Please check one:

☐ **Many** ☐ **Several** ☐ **A Few** ☐ **None**

Have you experienced a traumatic event in the past? Please check all that apply:

☐ **Domestic Violence** ☐ **Abuse** ☐ **Serious Accident** ☐ **Natural Disaster**

☐ **Other (please explain)**

_____

_____

Have you ever talked to anyone such as a psychologist, psychiatrist, counselor, minister/priest, etc, about your personal problems in the past? ☐ **Yes** ☐ **No**

If yes, who?

_____

Last contact date: _____

Please indicate any past hospitalizations in a mental health facility, if any.

Dates	Facility Name	Reason

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Are you currently taking any psychiatric medications? ☐ **Yes** ☐ **No**

If yes, please list current psychiatric medications:

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

Are these medications helpful? ☐ **Yes** ☐ **No** ☐ **Somewhat**

Have you taken any psychiatric medications in the past? ☐ **Yes** ☐ **No**

If yes, please describe:

_____

Were they helpful? ☐ **Yes** ☐ **No** ☐ **Somewhat**

Do you have a physical health condition or serious illness? ☐ **Yes** ☐ **No**

If yes, please describe:

_____

Are you taking any medications for a physical health condition or serious illness? ☐ **Yes** ☐ **No**

If yes, what medications?

_____

What do you hope to gain from counseling?

_____

_____

_____

_____

_____

_____

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BASIS-24 (Behavior and Symptom Identification Scale)

Time of Assessment: ☐ 1-Admission/Intake ☐ 2-Mid-treatment ☐ 3-Discharge/termination ☐ 4 Post-treatment follow up

Instructions to Respondents:

This survey asks about how you are feeling and doing in different areas of life. Please check the answer that best describes yourself during the PAST WEEK. Please answer every question. If you are unsure about how to answer, please give the best answer you can.

During the PAST WEEK, how much difficulty did you have –

1. Managing your day-to-day life?

☐ 0-No difficulty ☐ 1-A little difficulty ☐ 2- Moderate difficulty ☐ 3-Quite a bit of difficulty ☐ 4-Extreme difficulty

2. Coping with problems in your life?

☐ 0-No difficulty ☐ 1-A little difficulty ☐ 2- Moderate difficulty ☐ 3-Quite a bit of difficulty ☐ 4-Extreme difficulty

3. Concentrating?

☐ 0-No difficulty ☐ 1-A little difficulty ☐ 2- Moderate difficulty ☐ 3-Quite a bit of difficulty ☐ 4-Extreme difficulty

During the PAST WEEK, how much of the time did you…

4. Get along with people in your family?

☐ 0-None of the time ☐ 1-A little of the time ☐ 2-Half of the time ☐ 3-Most of the time ☐ 4-All of the time

5. Get along with people outside your family?

☐ 0-None of the time ☐ 1-A little of the time ☐ 2-Half of the time ☐ 3-Most of the time ☐ 4-All of the time

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6. Get along well in social situations?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

During the PAST WEEK, how much of the time did you -

7. Feel close to another person?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

8. Feel like you had someone to turn to if you needed help?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

9. Feel confident in yourself?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

During the PAST WEEK, how much of the time did you-

10. Feel sad or depressed?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

11. Think about ending your life?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

12. Feel nervous?

☐ **0-None of the time** ☐ **1-A little of the time** ☐ **2-Half of the time** ☐ **3-Most of the time** ☐ **4-All of the time**

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During the PAST WEEK, how often did you…

13. Have thoughts racing through your head?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

14. Think you had special powers?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

15. Hear voices or see things?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

16. Think people were watching you?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

17. Think people were against you?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

During the PAST WEEK, how often did you…

18. Have mood swings?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

19. Feel short tempered?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

20. Think about hurting yourself?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

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During the PAST WEEK, how often…

21. Did you have an urge to drink alcohol or take street drugs?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

22. Did anyone talk to you about your drinking or drug use?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

23. Did you try to hide your drinking or drug use?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

24. Did you have problems from your drinking or drug use?

☐ **0-Never** ☐ **1-Rarely** ☐ **2-Sometimes** ☐ **3-Often** ☐ **4-Always**

Thank you for taking the time to complete this survey.