Rosecrance is a behavioral health care organization that is bound by strict state and federal privacy and confidentiality regulations. Please fax this form. Do not email.

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Family/Significant Other (SO) Admission Self-Assessment

Client name _____ **Date of birth** _____

FAMILY MEMBER

Name _____ Relationship _____
Daytime phone: _____ Evening phone: _____
Cellular phone: _____ Best time to call: _____

How long have you know the client? _____
How long do you believe the client has had an addiction problem? _____
To your knowledge, how long has the client been using drugs or alcohol? _____

Please describe what made you realize that your loved one may have a problem? _____
_____
_____
_____
_____

Were there any significant incidents that happened in the client's early years, such as divorce, death, abuse, etc? _____
_____
_____
_____

How do you feel about your loved one being in treatment?
☐ Good ☐ Bad ☐ Relieved ☐ Ashamed ☐ It's all my fault ☐ Indifferent ☐ Angry
☐ Other: _____

How have you and your family sufferered as a result of your loved one's chemical use?
☐ Physical altercations ☐ Verbal altercations ☐ Social embarrassment ☐ Financial distress
☐ Community embarrassment ☐ Legal problems ☐ Excessive worry ☐ Infidelity
☐ Stolen money/credit cards ☐ Broken promises ☐ Employment problems ☐ Educational problems ☐ Insomnia ☐ Depression ☐ Other loved ones have suffered because focus has been on the client ☐ Other: _____
_____
_____
_____

rosecrance **Family/Significant Other Self-Assessment (cont.)**

BEHAVIORAL/EMOTIONAL

Has he/she ever shown signs of depression? Yes ☐ No ☐ Explain _____

Has he/she ever expressed suicidal thoughts? Yes ☐ No ☐ Explain _____

Has he/she ever has suicidal plans? Yes ☐ No ☐ Explain _____

Has he/she ever attempted suicide? Yes ☐ No ☐ Explain _____

Has he/she ever exhibited violent behavior? Yes ☐ No ☐ Explain _____

How does the patient deal with problems? _____

_____

ADOLESCENT CLIENTS ONLY

Has your son/daughter left home? Yes ☐ No ☐ Explain _____

Has your son/daughter left school? Yes ☐ No ☐ Explain _____

Has your son/daughter left a job? Yes ☐ No ☐ Explain _____

Has the client experienced any of the following, especially related to withdrawal from drugs?

Tremors Yes ☐ No ☐ Describe _____

Sweats Yes ☐ No ☐ Describe _____

Nausea/vomiting Yes ☐ No ☐ Describe _____

Hallucinations Yes ☐ No ☐ Describe _____

Seizures Yes ☐ No ☐ Describe _____

History of alcohol or drug overdose Yes ☐ No ☐ Describe _____

History of IV drug use? Yes ☐ No ☐ Describe _____

History of sedative use? Yes ☐ No ☐ Describe _____

ADOLESCENT CLIENTS ONLY

Has your son/daughter engaged in an act of self mutilation? Yes ☐ No ☐ Age of onset _____ Last episode _____ Describe _____

Has your son/daughter exhibited verbal aggression? Yes ☐ No ☐ Age of onset _____ Last episode _____ Describe _____

Has your son/daughter engaged in an act of physical aggression? Yes ☐ No ☐ Age of onset _____ Last episode _____ Describe _____

Are there guns in the home? Yes ☐ No ☐

rosecrance **Family/Significant Other Self-Assessment (cont.)**

Client name _____ **Date of birth** _____

LEGAL HISTORY

Date	Offense	Current status

Is the client on parole or probation? No ☐ Yes ☐ Reason: _____

When was the first time arrested? _____ Reason: _____

MEDICAL HISTORY

Has the client ever received treatment for drug/alcohol use? No ☐ Yes ☐ How many times: _____

Facility	Dates	Reason	Outcome

Has the client ever been treated for an emotional or psychiatric condition? (If yes, please describe.)

Facility	Dates	Reason	Outcome

FAMILY HISTORY OF CHEMICAL DEPENDENCY

Family member	Current	History
Father		
Mother		
Brother		
Sister		
Paternal grandparents		
Maternal grandparents		
Children		