rosecrance

ROSECRANCE, INC.
Family / Significant Other – Assessment

Family Member / Parent / Guardian / Significant Other: ***Please complete and give to the Receptionist.***

Client Name:		Client DOB:	
Family Member Name:		Relationship:	
Daytime phone:		Cellular phone:	
Evening phone:		Best time to call:	☐ AM ☐ Afternoon ☐ PM

How long have you known the client?	_____ Years
How long do you believe the client has had an addiction problem?	_____ Years
To the best of 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 occurred in the client's early years such as divorce, death, abuse, etc? ☐ Yes ☐ No

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 suffered as a result of your loved one's chemical use?

☐ Physical altercations	☐ Legal problems	☐ Employment problems
☐ Verbal altercations	☐ Excessive worry	☐ Educational problems
☐ Social embarrassment	☐ Infidelity	☐ Insomnia
☐ Financial distress	☐ Stolen money / credit cards	☐ Depression
☐ Community embarrassment	☐ Broken promises	☐ Other loved ones have suffered because focus has been on the client

Has he /she had difficulty remembering while under the influence? ☐ Yes ☐ No	Explain:
Has he / she made promises to quit using? ☐ Yes ☐ No	Explain:

What are some consequences the client has suffered as a result of his / her chemical use?

☐ Loss of family	☐ Loss of good reputation
☐ Divorce	☐ Spiritual deterioration
☐ Educational Problems	☐ Legal problems (burglary, violence, DUI)_____
☐ Loss of time from work	
☐ Emotional Problems	_____
☐ Losing friends	
☐ Depression	☐ _____
☐ Personality changes	
☐ Health Problems	☐ _____
☐ Financial problems	

Please describe what you believe the client's basic problem to be. Explain:

What are the client's strengths?:

Intelligent: ☐ Yes ☐ No Creative: ☐ Yes ☐ No Athletic: ☐ Yes ☐ No
Compassionate: ☐ Yes ☐ No Artistic: ☐ Yes ☐ No Loving: ☐ Yes ☐ No

Other strengths:

What are the client's weaknesses?:

Attitude: ☐ Yes ☐ No Follower: ☐ Yes ☐ No Learning disability: ☐ Yes ☐ No
Dishonesty: ☐ Yes ☐ No Criminal behavior: ☐ Yes ☐ No Resistance to learn: ☐ Yes ☐ No
Grades / Job: ☐ Yes ☐ No Choice of friends: ☐ Yes ☐ No

Other weaknesses:

Readiness to Change:

Using the ruler shown below, indicate how ready you believe the client is to make a change (quit or cut down) in the use of each of the drugs shown.

- **Not at all ready** to make a change, **circle the 1.**
- **Already trying hard** to make a change, **circle the 10**.
- **Unsure** whether they want to make a change, **circle 3, 4, or 5**.

Type of Drug	Not Ready to Change		Unsure			Ready to Change		Trying To Change			Doesn't Use
Alcohol	1	2	3	4	5	6	7	8	9	10	Doesn't Use
Drugs	1	2	3	4	5	6	7	8	9	10	Doesn't Use
Nicotine	1	2	3	4	5	6	7	8	9	10	Doesn't Use

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 had 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 client 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 you son / daughter left a job? ☐ Yes ☐ No	Explain:

Has the client experienced any of the following, especially related to withdrawal from taking drugs? *(If yes, describe)*		
Tremors	☐ Yes ☐ No	
Sweats	☐ Yes ☐ No	
Nausea / Vomiting	☐ Yes ☐ No	
Hallucinations	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No	
History of alcohol or drug overdose?	☐ Yes ☐ No	
History of IV drug use?	☐ Yes ☐ No	
History of sedative use?	☐ Yes ☐ No	

Adolescent Clients ONLY:				
		Age of onset	**Last episode**	**Describe**
Has your son / daughter engaged in any act of *self-mutilation*	☐ Yes ☐ No			
Has your son / daughter exhibited *verbal* aggression?	☐ Yes ☐ No			
Has your son / daughter exhibited *physical* aggression?	☐ Yes ☐ No			
Are there guns in the home?	☐ Yes ☐ No			

Does the client have a history of any of the following? If yes, please explain.	
Sexual abuse? ☐ Yes ☐ No	Explain:
Physical abuse? ☐ Yes ☐ No	Explain:
Emotional abuse? ☐ Yes ☐ No	Explain:
For adolescents only: Was abuse reported to DCFS? ☐ Yes ☐ No If yes, by whom?	

Adolescent Clients ONLY: Friends / Leisure Time	
Do you know your son's / daughter's/ friends? ☐ Yes ☐ No	Explain:
Do you approve of these friends? ☐ Yes ☐ No	Explain:
Any recent changes in son's / daughter's friends? ☐ Yes ☐ No	Explain:
Are you aware if any of his / her friends use? ☐ Yes ☐ No	Explain:
Do you approve of how he /she spends free time? ☐ Yes ☐ No	Explain:

Free time activities:

☐ Church	☐ Artwork	☐ On telephone
☐ Sports	☐ Clubs	☐ Watch TV
☐ Listening to music	☐ Shopping / mall	☐ Mechanical work
☐ Video / Computer games	☐ With friends	☐ Other: _____

Any involvement in gangs or cults? ☐ Yes ☐ No Explain:

Is the client welcome to return home after he / she completes treatment?	☐ Yes ☐ No
Is his / her return home contingent upon his / her progress in treatment?	☐ Yes ☐ No
Is the home of the client supportive of recovery?	☐ Yes ☐ No
Do alternate living arrangements need to be explored?	☐ Yes ☐ No

Legal

Date	Offense	Current Status

Is the client on parole or probation? ☐ Yes ☐ No	Reason:
When was the 1st time arrested?	Reason:

Has the client ever received treatment for drug /alcohol use? ☐ Yes ☐ No		**How many times?_____**	
Facility	**Dates**	**Reason**	**Outcome**

Has the client ever been treated for an emotional or psychiatric condition? ☐ Yes ☐ No (If yes, describe)			
Facility	**Dates**	**Reason**	**Outcome**

Family History of Chemical Dependency		
Family Member	**Current**	**History**
Father		
Mother		
Brother		
Sister		
Paternal Grandparents		
Maternal Grandparents		
Children		

Medical	
Does the client have any significant medical problems or diagnoses? ☐ Yes ☐ No	If yes, please list.
Does the client have any food or drug allergies? ☐ Yes ☐ No	If yes, please list.

Family Program	
Do you plan to participate in the Rosecrance Family Program?	☐ Yes ☐ No
Are you willing to attend an Al-Anon or other 12-step program?	☐ Yes ☐ No

Use the space below for additional comments (For adults or adolescents):

Reviewed and appropriately integrated into treatment plan _____