

Client Name:

CATT #:

MENTAL HEALTH/SUBSTANCE

PAST TREATMENT

Has the client ever been treated for a mental health condition by any of the following providers?

	Year(s)	Case Mgmt/ Therapy	Meds	Hospital		Year(s)	Case Mgmt/ Therapy	Meds	Hospital
<input type="checkbox"/> ATS/Wellness	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kettering Hospital	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CAM	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Miami Valley	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> DayMont	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> South Community	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eastway	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Summit	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Good Samaritan	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twin Valley	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Grandview	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> KBMC	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sam Behavioral	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous or Current Mental Health Diagnosis (if known)? _____

SUBSTANCE HISTORY (Complete each section below as appropriate)

Substance	No Use	Age of 1 st Use	Date of Last Use	Frequency of Use	Amount of Use	Date(s)/Location(s) of Treatment
Alcohol/Beer/Wine						
Marijuana						
Hallucinogens						
Stimulants						
Sleep Medication						
Inhalants						
Cocaine/Crack						
Heroin/Opioids						
Pain Medication						
Other:						
Caffeine use? If yes, form (coffee, tea, pop, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes					How much per week (cups, bottles)?	
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes					How much per week (packs, etc.)?	

FAMILY PHYSICIAN

Who is your Family Physician? _____

Would you like a referral to South Community Primary Care Yes No Not Sure

A LITTLE ABOUT YOU/YOUR CHILD!

Please let us know a little about the person to receive services.
For each item, indicate whether that area of your (your child's) life is a source of *problems/concern, going great, or is OK.*

Living Situation Problem OK Great

This includes how you (your child) feel about your home or where you (they) live.

Family Problem OK Great

This includes how well you (your child) get along with others in the family/with those you live.

Marital Status: Single Married Divorced Other/Self Describe _____

Are the members of your (your child's) family supportive?: Yes No Sometimes Unsure

Is there a history in your (your child's) family of (check all that apply):
 Mental Health Issues Substance Abuse Trauma Legal Issues

Who in your (child's) home/family is most supportive? _____

With whom do you (child) have the most problems? _____

Social Problem OK Great

This includes how you/your child get along with and what you do with other people who are NOT related to you or live with you.

I feel good about the number of and relationships I (my child) have with friends: Yes No

I am (my child is) involved in the following meaningful activities (check all that apply):
 Volunteer Activities Recreational Activities Community Involvement Other: _____

I am (my child is) involved in the following support Groups (check all that apply):
 NAMI AA/NA Other: _____

Caring for Myself Problem OK Great

This includes how well you believe you (your child) are able to take care of basic tasks of everyday life, such as eating, bathing, dressing, making appointments, managing your money.

Religion/Spirituality Problem OK Great

This may include your (your child's) religious and spiritual beliefs and actions or others' reactions to your beliefs and actions.

Culture/Ethnicity Problem OK Great

This may include your (your child's) beliefs, customs, attitudes or race with that you identify or feel distinguishes you.

How can we help make your cultural/ethnic experience more successful? _____

Sexual Orientation & History Problem OK Great

This may include your (your child's) feelings toward sex, sexuality, sexual orientation or gender expression.

Client identifies as: Straight/Heterosexual Gay Lesbian Bi-Sexual Asexual Other

Gender

Client identifies as: Male Female Transgender Gender Fluid Self-Describe: _____

Education

Problem OK Great

This includes any information related to school, such as learning, peer/teacher relationships, attendance, and behavior.
Are you (your child) currently attending school? Yes No If yes, where? _____
If yes, do you (your child) have an IEP? Yes No If yes, for what? _____
History of Learning/Developmental Challenges:
 NONE Learning Disability Developmental Delays Special School Placement Other: _____
Other Problems: Suspensions Attendance Grades Behavior Other _____

Legal

Problem OK Great

This includes any information related to your (your child's) past or current legal involvement.
Current Legal Status:
 None Reported On Probation Detention On Parole Awaiting Charge Outpatient Commitment
 Other _____
Past Legal Status::
 None Reported On Probation Detention On Parole Awaiting Charge Outpatient Commitment
 Other _____

Lethality

Problem OK Great

This includes any information related to your (your child's) past or current harm to self or others.
Current: None Reported Thoughts to harm self Thoughts to harm others Attempts to harm self Attempts to harm others
Past: None Reported Thoughts to harm self Thoughts to harm others Attempts to harm self Attempts to harm others

Employment

Problem OK Great

This includes information related to your (your child's) employment, including ability to learn/complete tasks, relationships, attendance, and corrections
I am (my child is) currently:
 Not employed Employed Full Time Employed Part Time Volunteer Work Seeking Employment
If you (your child) are not employed, are you (your child):
 Disabled Retired Homemaker Student Other: _____
Are you interested in employment? Yes No Not Sure
Job Performance: **Attendance:** No Problems Frequent Tardiness Frequent Absences Not Applicable
Performance Exemplary Good Average Below Average

Abuse History

Problem OK Great

This includes any information related to past or current abuse where you (your child) were the victim or perpetrator.
 None Reported Physical Sexual Emotional Neglect Domestic Violence Community Violence
 Other _____

Signature of Client/Guardian

Date

Signature of Witness

Date