



Collaborative Change Initial Checklist – *ADULT*

Name of person completing form: _____ Date: _____

PRESENTING ISSUE

1. What is the primary reason for which you are seeking help? (please check)

2. How long have you have this issue(s) been present?

3. Have you received treatment for this issue or any other issue in the past? Yes No

FAMILY HISTORY

1. Have you had any family history of alcohol abuse within your family (Please circle all that apply):

2. Have you had any family history of drug abuse within your family (Please circle all that apply):

2. Was there any type of abuse in your family/home? Yes No

If yes, please check which: Physical Abuse Sexual Abuse Emotional Abuse Domestic Violence



MEDICAL HISTORY

1. Please check the appropriate box if you have experienced any of these issues:

- | | |
|--|--|
| <input type="checkbox"/> Eye disease, injury, poor vision | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ear disease, injury, poor hearing | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Nose, sinus, mouth, throat problems | <input type="checkbox"/> Hemorrhoids, rectal bleeding |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Convulsions or seizures | <input type="checkbox"/> Frequent or severe headaches |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Extreme tiredness or weakness | <input type="checkbox"/> Neck stiffness, pain, swelling |
| <input type="checkbox"/> Thyroid disease or goiter | <input type="checkbox"/> Marked weight changes |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Allergies or asthma |
| <input type="checkbox"/> Back, arm, leg or joint problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Premenstrual Syndrome (PMS) | <input type="checkbox"/> Pregnancy not carried to term/stillbirths |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Liver, gallbladder disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest pain or angina pectoris | |

2. Please explain anything checked above:

3. Please circle which best describes your sleeping patterns: