MIDDLESEX COUNTY
CENTER FOR EMPOWERMENT

TO BE COMPLETED BY STAFF
Case # _____
Cnslr Initials _____

Date: _____ Name of Person Completing Form: _____

Client Name: _____ Minor, Parent's Name(s): _____

Address: _____ Address of Parent (if different): _____

_____ _____

OK to send mail to this address? (Y/N) ____ ☐ Check here if post mail is preferred contact

Note: Return address will be Middlesex County Office of Health Services

Email Address: _____

OK to send email to this address? (Y/N) _____ ☐ Check here if email is preferred contact

Note: Return address will be empowerment@co.middlesex.nj.us

Primary Phone #: _____ ☐Home ☐Cell ☐Work **OK to leave messages**? (Y/N) ____

Secondary Phone #: _____ ☐Home ☐Cell ☐Work **OK to leave messages**? (Y/N) ____

Gender: ☐ Male ☐ Female ☐ Transgender Date of Birth: _____/_____/_____ Age: _____

Race/Nationality: _____ Religion: _____

Marital Status: ☐ Married ☐ Marriage type relationship ☐ Divorced/Separated ☐ Widowed
☐ Single/Never Married ☐ Currently in a Significant Relationship ☐ Not in a Significant Relationship

Sexual Orientation/Identity: ☐ Heterosexual ☐ Lesbian/gay/homosexual
☐ Bisexual ☐ Other (please specify): _____

Children? (Y/N) _____ If yes, name(s)/age(s): _____

Education: ☐ High School ☐ College ☐ Advanced Degree ☐ Other: _____

If Minor: Grade _____ Name of School: _____

Employment: ☐ Unemployed ☐ Part-time ☐ Full-time

Type of Work: _____ Employer: _____

Sources of Income: ☐ Disability ☐ Welfare ☐ Other: _____

Referred by: _____

Reason for Coming: ☐ Sexual Assault/Rape ☐ Child Sexual Abuse ☐ Other: _____
☐ Of Self ☐ Of Loved One

Law Enforcement Involvement: ☐ Reported to Police ☐ Not Reported ☐ Undecided

Interested in: ☐ Individual Counseling ☐ Support Group ☐ Legal Support/Accompaniment

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NOTES:

CURRENT/RECENT SYMPTOMS EXPERIENCED (Please Check):

- ☐ Difficulty falling asleep
- ☐ Interrupted sleep
- ☐ Early awakening
- ☐ Hypersomnia
- ☐ Decreased need for sleep
- ☐ Nightmares

- ☐ Overeating
- ☐ Loss of appetite
- ☐ Weight gain of _____lbs.
- ☐ Weight loss of _____lbs.

- ☐ Withdrawal
- ☐ Crying
- ☐ Feelings of worthlessness
- ☐ Fatigue
- ☐ Feeling slowed down
- ☐ Loss of interest in usual activities
- ☐ Feelings of hopelessness

- ☐ Heart pounding
- ☐ Fast pulse or breathing
- ☐ Sweating
- ☐ Cold, clammy hands
- ☐ Dry mouth
- ☐ Lump in throat
- ☐ Difficulty swallowing
- ☐ Light headedness/dizziness
- ☐ Tingling in hands/feet
- ☐ Shortness of breath
- ☐ Smothering sensation
- ☐ Nausea
- ☐ Abdominal pain/distress
- ☐ Chills
- ☐ Chest pain
- ☐ Trembling

- ☐ Feelings of dissatisfaction
- ☐ High energy level
- ☐ Irritability
- ☐ Excessive anger
- ☐ Overspending
- ☐ Excessive sexual activity
- ☐ Feeling unusually creative/productive
- ☐ Overly high energy level
- ☐ Low frustration tolerance
- ☐ Feeling jittery
- ☐ Muscle tension
- ☐ Twitches
- ☐ Feeling restless
- ☐ Impatience

- ☐ Diminished ability to think
- ☐ Poor concentration
- ☐ Distractibility
- ☐ Thoughts Racing
- ☐ Mind going blank

- ☐ Suicidal thoughts
- ☐ Homicidal thoughts

- ☐ Guilt
- ☐ Worry
- ☐ Fear
  - ☐ Fear of losing control
  - ☐ Fear of Dying
  - ☐ Other: _____
- ☐ Flashbacks
- ☐ Changes in sexuality/intimacy

- ☐ Anticipation of misfortune

- ☐ Feeling isolated
- ☐ Feeling detached
- ☐ Feeling lack of intimate connection
- ☐ Hallucinations:
- ☐ Delusions:

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NOTES:

Case #_____

CLIENT HISTORY:

Alcohol/Drug History:

Current Substances Used**:** ☐ None

☐ Alcohol: How much? _____ How often? _____

☐ Tobacco: How much? _____ How often? _____

☐ Caffeine: How much? _____ How often? _____

☐ Drugs (list):_____

How much? _____ How often?_____

Has your use of any of the above changed recently? (Y/N) ___ If yes, explain: _____

_____

_____

Do you have a substance abuse problem? (Y/N) ___

Have you ever been treated for substance abuse? (Y/N) ___If yes, explain: _____

_____

_____

Do you have a family history of substance use/abuse? (Y/N) ____ If yes, explain: _____

_____

_____

Medical History:

Please list any current medical problems:_____

_____

_____

Current Treatment / Medications: _____

_____

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NOTES:

Case #_____

Psychiatric History:

Have you ever been hospitalized for mental illness(Depression, Anxiety, Schizophrenia, etc.)?(Y/N)___

If yes, explain (include dates and location): _____

_____

Have you ever been in counseling before? (Y/N) ____If yes, explain (include dates/practitioner(s)):_____

_____

_____

Current Medications: _____

Prescribed by: ☐ General Physician ☐ Psychiatrist

Please explain purpose of medications: _____

_____

Have you ever attempted suicide? (Y/N) ____ If yes, when? _____

Did the attempt result in a hospitalization/medical treatment? (Y/N) ___ If yes, explain:_____

_____

Do you have any current thoughts of suicide? (Y/N) ____

Have you ever engaged in self harm (cutting, burning, etc.): (Y/N) ____ If yes, explain method:

_____

Has self harm ever resulted in a hospitalization/medical treatment? (Y/N) ____

Do you currently self harm? (Y/N) ____If yes, how often?_____

If yes, has there been any change recently in frequency/method? (Y/N) ____If yes, explain:____

_____

If no, when was last episode?_____

Do you have any family history of mental illness / emotional problems / suicide: (Y/N) ____

If yes,explain:_____

_____

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NOTES:

Case #_____

Personal and Family History:

Other than the reason for your visit, have you experienced any other significant trauma in your lifetime? (Y/N) ___ If yes, please explain: _____

_____

_____

What other stressors do you currently have in your life?_____

_____

_____

How would you describe your peer relationships/friendships?

☐ Satisfied ☐ Dissatisfied (explain):_____

_____

To whom have you confided about the sexual violence? _____

_____

Are they: ☐ supportive ☐ unsupportive

What sources of support/strength do you have in your life? _____

_____

_____

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NOTES: