STRESS CARE OF NEW JERSEY, LLC
Tel. #: 732-679-4500 Fax #: 732-679-4549
www.stresscareclinic.com

PLEASE FILL IN THE FOLLOWING INFORMATION:

Patient Name: ______________________________ Date of Birth: _______________

Race/Ethnicity: ____

Family or Other Designated Contact Person(s): ____________________________________

Relationship: ____

Telephone #: ____

Permission to Contact: ___Yes ___No Signed Consent Release Form: ___Yes __No

SOCIAL HISTORY:
Names of Family/Friends who reside in home with client:____________________________________

____

Relationship with peers: ____ Excellent ____ Good ____ Fair ____ Poor

Spiritual and Religious Orientation: ____

How do you see this having an impact on your treatment success? ______________________________

____

Cultural Orientation: ____

How do you see your cultural traditions impacting your treatment success? ________________________

____

EDUCATIONAL HISTORY:
Highest Level of Education Completed ____________________ Degree earned ________________
How are/were your grades: ____ Excellent ____ Good ____ Fair ____ Poor

WORK HISTORY:
Type of last job: ____

Length of Employment:_________________ Last date employed if applicable: _______________

Financial Issues/Problems: ____

HISTORY OF PHYSICAL/SEXUAL/EMOTIONAL ABUSE/NEGLECT/EXPLOITATION:
Physical: ___Yes ___No By whom: _____________ How long: ____________
Sexual: ___Yes ___No By whom: _____________ How long: ____________
Emotional: ___Yes ___No By whom: _____________ How long: ____________

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CRITICAL EVENTS IN YEARS OF AGE or Mark N/A:
(Please describe any critical events that occurred throughout the years)

0-5

6-12

13-17

18-21

22-29

30+

FAMILY RELATIONSHIPS:

Children:	___ Good ___ Very Good ___ Fair ___ Poor
Parents:	___ Good ___ Very Good ___ Fair ___ Poor
Siblings:	___ Good ___ Very Good ___ Fair ___ Poor
Spouse/Significant Other:	___ Good ___ Very Good ___ Fair ___ Poor

STRENGTHS/WEAKNESSES:

(CHECK ALL THAT APPLY)	(CHECK ALL THAT APPLY)
STRENGTHS IDENTIFIED	**PROBLEMS IDENTIFIED**
Intact Support System	Hx of not taking meds/aftercare treatment
Knowledge of Illness	Lack of Insight into Illness
Motivated for Treatment	Uncooperative
Pleasant, Cooperative	Unemployed
Presently Employed	Poor/No Impulse Control
Skilled, Educated	Other

PSYCHOEDUCATIONAL NEEDS (CHECK ALL THAT APPLY)

Addiction Education	Medication Education
Coping Skills	Education of Illness
Relaxation Skills	Anger Management Skills
Socialization Skills	Anxiety Management Skills
Other	

Describe areas of weakness and difficulty functioning, including causes and contributing factors:

____

Patient Strengths and Resources: How do you manage to maintain your safety and self-control? (Personal and community resources): ____

Are you involved in any Community Services or with any Outside Agencies (support groups; social services; school based services; DCF; probation; etc.) _______________________________________

____

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Family: What do you hope for your loved one to get out of treatment?

____

Patient: What would you like the outcome of your treatment to be?

____

NUTRITIONAL SCREENING:

1. Do you have a history of Eating Disorder? ___Yes ___No
2. Do you eat extremely small amounts of food? ___Yes ___No
3. Do you eat extremely large amounts of food? ____Yes __No
4. Do you think you are too fat? ___Yes ___No
5. Do you think you are too thin? ____Yes __No
6. Do you eat healthy (i.e., fruits, vegetables)? __Yes __No
7. What are your beliefs, perceptions, attitudes and behaviors regarding food?
   ____
8. What are the family/support(s) observations regarding your food-related beliefs?
   ____

If you answer “Yes” to any question above, it is advised that you contact a nutritional specialist or talk to your PCP.

PAIN SCREENING:

1. Are you experiencing physical pain now? __ Yes ___No
2. Describe the pain you have every day: ____Severe ___Moderate __Mild
3. Are you in treatment at a Pain Management clinic: ___Yes ___No
4. Is your pain caused by an injury/surgery? __Yes ___No
5. Describe injury/surgery: ____
   ____
6. Date of injury/surgery: ____

If you answer “Yes” to question #1, it is advised to contact a Pain Management specialist or talk to your PCP

I certify by checking the box and printing my name below that the above information is correct to the best of my knowledge.

Click here to Acknowledge

____ ____________________
Patient Printed Name Date

I have reviewed the above information.

____ ____________________
Provider Signature Date