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) **STRENGTHS IDENTIFIED**		(CHECK ALL THAT APPLY) **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