STRUCTURED CLINICAL INTERVIEW

Date: _____ Case #_____

Name: _____
Date of Birth: _____ Age: _____
Social Security #: _____
Address: _____
City _____ State: _____ Zip: _____
Home: _____ Work Phone: _____ Cell Phone: _____
E-mail Address: _____

Ethnicity (check as many as apply):

(1) Anglo _____
(2) Asian _____
(3) Black _____
(4) Chicano/a _____
(5) Hispanic _____
(6) Latino/a _____
(7) Mexican American _____
(8) Native American _____
Tribe: _____
(9) Other _____

Current Marital Status (indicate number of years):

(1) Single, never married _____
(2) Married _____
(3) Living together _____
(4) Separated _____
(5) Divorced _____

Sexuality:

(1) Straight/Heterosexual _____
(2) Gay _____
(3) Lesbian _____
(4) Bisexual _____
(5) Other _____

Living Situation (List all the people who live with you now):

(1) Living with spouse _____
(2) Living with partner _____
(3) Living alone _____
(4) Living with roommate _____
(5) Living with children _____
(6) Living with parents _____
(7) Living with other-specify _____
Relationship to other party _____

Annual Income: [Job:_____]

(1) Under $10,000 _____
(2) $10,000-$19,000 _____
(3) $20,000-$29,000 _____
(4) $30,000-$39,000 _____
(5) $40,000-$49,000 _____
(6) Over $50,000 _____

Education (indicate year):

(1) Grades 1-8 _____
(2) Grades 9-12 _____ Last grade completed: _____
(3) High School Graduate _____ GED? _____
(4) 1-2 years of college _____
(5) 2+ years of college _____
(6) College graduate _____ Type of Degree: _____
(7) Post graduate work _____
(8) Graduate degree _____ Type of Degree: _____
(9) Technical/Vocational _____ What Type? _____

Relationship Overview:

How long have you known the other parent (*current opposing party)?* _____
Dated: _____ Lived together: _____ Married: _____ (dates, length)
Are you together now? Y N
If no, date of separation/divorce: _____
When did you last live together? _____
Is there a restraining order in place? Y N
If yes, when does the order expire (date)?_____ Is it stipulated? Y N
Have there been previous restraining orders? Y N *If yes*, how many? _____
How many times have you been before a Domestic Violence Commissioner/Judge? _____

Family of Origin:

Where were you raised? _____
What was the primary language spoken in your home during childhood? _____
Growing up, who was in your family: _____
_____
_____
What was your relationship like with (e.g., parents, siblings, grandparents)?_____
_____
_____
_____

Parents' current marital status: (circle)
Still Married Divorced Remarried Deceased
If deceased: (circle) Mother Father
If deceased: client's age at time of parent's death? _____
If divorced: client's age at time of divorce? _____
If divorced: step-parents? Y N
What was your relationship with your step-parents like? _____
_____
Did you see both parents regularly after the divorce? Y N
If no, why not?_____

Did your mother drink alcohol and/or use drugs? Y N DK

If yes: Alcohol Drugs Both

If yes, how much did your mother drink alcohol/use drugs? (circle one)

Never Occasionally Regularly

Was it ever a problem for your family? _____

If yes, tell me more: _____

_____

Did your father drink alcohol and/or use drugs? Y N DK

If yes: Alcohol Drugs Both

If yes, how much did your father drink alcohol/use drugs? (circle one)

Never Occasionally Regularly

Was it ever a problem for your family? _____

If yes, tell me more:_____

_____

Growing up, did one of parents ever hit or beat up your other parent? Y N

If yes, how many times can you recall this happening? _____times.

Did your father ever hit your mother? Y N How old were you? _____

Did your mother ever hit your father? Y N How old were you? _____

Did your parents ever hit or beat up each other at the same time? Y N DK

If yes, how often?_____

When these kinds of incidents happened……

Were alcohol and/or drugs involve? Y N DK

Did you see it happen? Y N

If yes, how old were you? _____

Did it result in someone needing medical care of the police being called? Y N

Did your family have any other stressors or problems (financial, legal, medical, unemployment, child behavioral problems, drug abuse, physical/mental illness, extra marital affairs, etc.)? _____

_____

_____

Childhood Physical Abuse:

Growing up, did a parent or another adult ever do anything to you on purpose that made you bleed, that gave you bruises, or that broke bones or teeth? Y N

If yes, how often*?* _____

How old were you the first time? _____ Last time? _____

Did you ever receive medical attention as a result? Y N

Childhood Sexual Abuse:

Growing up, did anyone ever touch or kiss you in a sexual or inappropriate way? Y N

Did anyone ever do anything to you sexually that you did not consent to? Y N

If yes, with who? _____

_____

If yes, did you tell anyone about it? Y N

If yes, who did you tell and what happened? _____

_____

History of Abusive Relationship

Have you ever been hit or hurt by the other parent? Y N

If yes, how many times? _____

Has there been verbal, emotional, and/or sexual abuse? Y N

If yes, please describe: _____

_____

If yes, were alcohol and/or drugs involved? Y N

If yes, how much had you usually had to drink? _____

How much had the other person to drink? _____

What kinds of drugs had you used? _____

What kinds of drugs had the other person used? _____

Have you ever hit or hurt your spouse/partner? Y N

If yes, how many times? _____

Has there been verbal, emotional, and/or sexual abuse? Y N

If yes, please describe: _____

_____

If yes, were alcohol and/or drugs involved? Y N

If yes, how much had you usually to drink? _____

How much had the other person to drink? _____

What kinds of drugs had you used? _____

What kinds of drugs had the other person used? _____

Have you been in any other relationship in which your spouse/partner hit/hurt you? Y N

If yes, when? _____

Have you ever received medical treatment as a result of a spouse/partner hitting you? Y N

If yes, when? _____

Have you ever been hospitalized as a result of a spouse/partner hitting you? Y N

If yes, when? _____

Have you ever had an affair with someone while you were in this relationship? Y N

Does your spouse/partner accuse you of having affairs? Y N

Has your relationship with your family changed since you have been in this relationship? Y N

If yes, how? _____

Has your relationship with you friends changed since you have been in this relationship? Y N

If yes, how? _____

Have you shared a checking account or a savings account with your spouse/partner? Y N

Do you feel like financial decisions were made fairly? Y N

If no, why? _____

Do you believe your spouse/partner would feel that financial decisions were made fairly? Y N

If no, why? _____

Do you feel like you were not allowed to work outside the home? Y N

If yes, how? _____

Have you ever tried to end the relationship? Y N

If yes, how many times (date)? _____

Are you planning to end the relationship? Y N *If already ended, when?* _____

Describe the incident(s) that precipitated the restraining order (give date, describe what led up to incident, incident in detail, were weapons used, who was present, what happened afterward, were drugs or alcohol involved, was there kicking, pushing, etc.) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Juvenile Legal History [Note: Age, Charge, Outcome]

Before age 18, were you ever arrested? Y N

If yes, tell me more:_____

_____

_____

Adult Legal History:

Do you have any *charges pending*? Y N

If yes, for what? _____

_____

Have you ever been *arrested?* Y N

If yes, when? _____

_____

Have you ever spent *time in jail*? Y N

If yes, for what and for how long? _____

Have you ever been *convicted*? Y N

If yes, when and what was the sentence? _____

_____

If on probation, name of officer: _____

Have you ever been *accused* of child abuse? Y N

If yes, when and for what? _____

_____

Have you ever been *convicted* of child abuse? Y N

If yes, what was the sentence? _____

Partner's History:

Did the other parent (current opposing party) have problems with:

Maintaining jobs (being fired, unemployed)?	Y	N	DK
Maintaining a permanent residence?	Y	N	DK
Maintaining relationships (family, friends, partners)?	Y	N	DK
Being responsible (money, driving, parenting)?	Y	N	DK
Using excessive amounts of alcohol &/or drugs?	Y	N	DK
Getting into fights?	Y	N	DK
Weapons? Y N			
Making threats?	Y	N	DK
Weapons? Y N			
Being involved in criminal activities?	Y	N	DK
Destroying property?	Y	N	DK
Stealing (family, friends, outside the home)?	Y	N	DK
Being physically cruel to animals?	Y	N	DK

Children:

(1) Name: _____ (circle) Male Female

Age: _____ DOB: _____

Is this child a child of the party in this case? Y N

With whom is the child living? Mother Father other: _____

When was the last time you saw this child? _____

Is there a time-share order? Y N

If yes, describe: _____

Supervised visits? Y N (circle) Mother Father

If yes, supervised by whom? _____

Is this child experiencing any emotional or behavioral problems? (circle all that apply)

Sadness Anger Aggression Irritability Crying Fighting

Nightmares Wetting the bed Eating/appetite problems Sleep problems

School problems Desire to see the other parent Other: _____

Has your child been diagnosed with any medical or learning problems? Y N

Depression ADHD autism other: _____

Has the child witnessed any violence? Y N

If yes, when? _____

Describe incident(s): _____

_____

Has your child received counseling? Y N

If yes, with whom? _____

Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N

If yes, how, who, and when? _____

_____

If yes, is it likely that this will ever happen again? Y N

Is Child Protective Services (CYFD) involved? Y N

Would your child benefit from counseling? Y N

_____

(2) Name: _____ (circle) Male Female
Age: _____ DOB: _____
Is this child a child of the party in this case? Y N
With whom is the child living? Mother Father other: _____
When was the last time you saw this child? _____
Is there a time-share order? Y N
If yes, describe: _____
Supervised visits? Y N (circle) Mother Father
If yes, supervised by whom? _____
Is this child experiencing any emotional or behavioral problems? (circle all that apply)
Sadness Anger Aggression Irritability Crying Fighting
Nightmares Wetting the bed Eating/appetite problems Sleep problems
School problems Desire to see the other parent Other: _____
Has your child been diagnosed with any medical or learning problems? Y N
Depression ADHD autism other: _____
Has the child witnessed any violence? Y N
If yes, when? _____
Describe incident(s): _____
_____
Has your child received counseling? Y N
If yes, with whom? _____
Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N
If yes, how, who, and when? _____
_____
If yes, is it likely that this will ever happen again? Y N
Is Child Protective Services (CYFD) involved? Y N
Would your child benefit from counseling? Y N

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(3) Name: _____ (circle) Male Female
Age: _____ DOB: _____
Is this child a child of the party in this case? Y N
With whom is the child living? Mother Father other: _____
When was the last time you saw this child? _____
Is there a time-share order? Y N
If yes, describe: _____
Supervised visits? Y N (circle) Mother Father
If yes, supervised by whom? _____
Is this child experiencing any emotional or behavioral problems? (circle all that apply)
Sadness Anger Aggression Irritability Crying Fighting
Nightmares Wetting the bed Eating/appetite problems Sleep problems
School problems Desire to see the other parent Other: _____
Has your child been diagnosed with any medical or learning problems? Y N
Depression ADHD autism other: _____
Has the child witnessed any violence? Y N
If yes, when? _____

Describe incident(s): _____

_____

Has your child received counseling? Y N

If yes, with whom? _____

Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N

If yes, how, who, and when? _____

_____

If yes, is it likely that this will ever happen again? Y N

Is Child Protective Services (CYFD) involved? Y N

Would your child benefit from counseling? Y N

_____

(4) Name: _____ (circle) Male Female

Age: _____ DOB: _____

Is this child a child of the party in this case? Y N

With whom is the child living? Mother Father other: _____

When was the last time you saw this child? _____

Is there a time-share order? Y N

If yes, describe: _____

Supervised visits? Y N (circle) Mother Father

If yes, supervised by whom? _____

Is this child experiencing any emotional or behavioral problems? (circle all that apply)

Sadness Anger Aggression Irritability Crying Fighting

Nightmares Wetting the bed Eating/appetite problems Sleep problems

School problems Desire to see the other parent Other: _____

Has your child been diagnosed with any medical or learning problems? Y N

Depression ADHD autism other: _____

Has the child witnessed any violence? Y N

If yes, when? _____

Describe incident(s): _____

_____

Has your child received counseling? Y N

If yes, with whom? _____

Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N

If yes, how, who, and when? _____

_____

If yes, is it likely that this will ever happen again? Y N

Is Child Protective Services (CYFD) involved? Y N

Would your child benefit from counseling? Y N

_____

Sources of Support: [family, friends, church, hobbies, etc.]

_____

_____

_____

_____

Medical History:

Have you ever had a head injury (e.g., concussion, "knocked out")? Y N

If yes, how old were you? _____

Have you ever lost consciousness? Y N

If yes, what was the longest length of time you were unconscious?_____

What was the cause of injury? _____

_____

[*Ask about anything on F.A.I.R. Questionnaire that needs clarification:*_____

_____].

Psychiatric History:

Before the age of 18, did you ever see a counselor for any reasons? Y N

If yes, why?_____

_____

Have you seen a counselor, psychologist, etc. since age 18? Y N

If yes, what kind? _____

Have you ever been in a hospital for emotional problems? Y N

If yes, what kind? _____

How long (dates)? _____

Have you ever taken medication for emotional problems (depression, anxiety, etc.)? Y N

If yes, what kind of medication? _____

Who prescribed the medication (name; psychiatrist, primary care physician, etc.)?_____

_____

Do you believe that you currently have (or have had in the past) an alcohol problem? Y N

If yes, have you received treatment? Y N

If yes, describe: _____

_____

Do you believe that you currently have (or have had in the past) a drug problem? Y N

If yes, have you received treatment? Y N

If yes, describe: _____

_____

Are you currently having any sleep difficulties? Y N

If yes, describe: _____

Duration of problem: _____

Are you having any appetite problems? Y N

If yes, describe: _____

Are you experiencing any weight loss or gain? Y N Intentional? Y N

If yes, how much? _____

Have you ever experienced episodes of depression? Y N

If yes, when ? _____ duration? _____ no.? _____

Have you ever received treatment for depression? Y N

If yes, describe treatment: _____

Have you ever tried to hurt yourself or commit suicide? Y N

If yes, when? _____

During the past year have you felt like hurting yourself or committing suicide? Y N

Do you currently feel like hurting yourself? Y N

If yes, tell me more: _____

_____

Do you currently feel like hurting anyone? Y N

If yes, who (*get as much information as possible*)? _____

_____

Do you feel hopeless, like things will only get worse? Y N

Anxiety: (circle one) none mild moderate severe

[Are you anxious? Do you feel nervous, tense, on edge, etc.]

Have you ever received treatment for anxiety? Y N

If yes, describe treatment: _____

Obsessions: (circle one) none presenting problems other

[Do you ever have thoughts that you can't get out of your mind, no matter how hard you try?]

Other: _____

Compulsions: Y N *If yes*: _____

[Any rituals/routines that you have to do in a certain way, or else you get upset?]

Thought Content-Hallucinations: (circle one) none auditory visual olfactory

[Do you ever feel like your mind is playing tricks on you-hearing things, seeing thing, smelling thing no one else can?]

Thought Content- Delusions: (circle) none persecution somatic ideas of reference thought broadcasting jealousy grandiosity control by others religious influence by others other: _____

Memory concerns: (circle) Y N

[Is your memory as good as it has always been?]

*If yes, (describe):*_____

<u>Mental Status Examination (to be completed by clinician):</u>

Appearance ☐ Well groomed ☐ Disheveled ☐ Bizarre ☐ Inappropriate

Attitude ☐ Cooperative ☐ Guarded ☐ Suspicious ☐ Uncooperative ☐ Belligerent

Motor Activity ☐ Normal ☐ Hypoactive ☐ Hyperactive ☐ Agitated ☐ Tremors/Tics ☐ Others

Mood ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Euphoric ☐ Other

Affect ☐ Appropriate ☐ Labile ☐ Expansive ☐ Constricted

Speech ☐ Normal ☐ Delayed ☐ Slurred ☐ Excessive ☐ Loud ☐ Soft

☐ Perseverating ☐ Pressured ☐ Incoherent ☐ Paucity ☐ Errors

Self-Perception ☐ No Impairment ☐ Derealization ☐ Depersonalized

Orientation ☐ Intact ☐ Impairment: ☐ Always ☐ Sometimes ☐ Time ☐ Place ☐ Person

Attention/Concentration ☐ Normal ☐ Fluctuating ☐ Distractible ☐ Hyper?

Memory ☐ Intact ☐ Impairment: ☐ Immediate ☐ Recent ☐Remote ☐Blackouts ☐ Amnesia

Cognitive Function General Knowledge Intact ☐ Yes ☐ No

Thought Process ☐ Intact ☐ Circumstantial ☐ Tangential ☐ Flight of Ideas

☐ Loose Associations

Thought Content/Perception

1. Hallucination: ☐ Not Apparent ☐ Present, impairment: ☐ Mild ☐ Moderate ☐ Severe

2. Delusions: ☐ Not Apparent ☐ Present, impairment: ☐ Mild ☐ Moderate ☐ Severe

Apparent Impulse Control ☐ Normal ☐ Undercontrolled ☐ Overcontrolled
Judgment ☐ Within Normal Limits ☐ Impairment: ☐ Minimal ☐ Moderate ☐Severe
Insight ☐ Within Normal Limits ☐ Impairment: ☐ Minimal ☐ Moderate ☐ Severe
Comments: _____

_____

_____

_____

Goals for Treatment:

Given that you have been ordered to participate in this program, what would you like to get out of treatment? _____

_____

_____

_____

_____

_____

_____

Need for Referral:

If this individual needs outside referral, describe issue: _____

_____

_____

Children's Need for Referral (6 and under)

If the child(ren) needs an outside referral, describe issue: _____

_____

_____

Additional Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____