PALOMAR COLLEGE
Learning for Success

Behavioral Health Counseling Services
Functional Assessment Form **Date Completed:** _____

Student Contact Information:
Student Name:_____
ID #: _____Email:_____
Student's Contact Number: _____
Appointment Made: _____ Date: _____Time: _____

Referring Party/Name:_____
Department (Please circle):
Counseling **/** Health Services / DRC / EOPS / Veterans
Student Services Administration / Other (describe):
_____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:_____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Identity problems
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories
- ☐ Traumatic Event

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances
- ☐ Other: _____

☐Yes ☐No Have you ever had thoughts, made statements, or attempted to hurting or killing yourself?

If yes, when did you last experience these thoughts/feelings? _____ Please describe:_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else?

If yes, please describe:_____

☐Yes ☐No Have you recently been physically hurt or threatened by someone else? If yes, please describe:

_____

Are you or anyone else concerned about your use of drugs and/or alcohol? ☐ Yes ☐ No Who? _____

Consequences of Using/Drinking (Check or mark ☐ if these consequences have occurred):

Relationships	**Work/School/Finances**
❑ Family members/friends have expressed concerns about your using/drinking. ❑ Loss of friends due to using/drinking. ❑ Loss of girlfriend/boyfriend/spouse due to use. ❑ Decreased time spent with family.	❑ Lost time at work/school ❑ Lost job or had multiple jobs ❑ Expelled/suspended at school or dropped out ❑ Lost $ or spent significant $ on alcohol/drugs
Accidents (Dangerous activity)/Arrests (Legal)	**Health Problems/Emotional Consequences**
❑ Injuries/accidents while using/drinking ❑ Rage/violence while using/drinking ❑ Legal difficulties/probation/pending court date ❑ Arrests/Jail time/Juvenile Hall time ❑ Illegal activity in order to supply drugs or alcohol (stealing, dealing).	❑ Paranoia or unrealistic fears ❑ Hallucinations during or after use/drinking ❑ Suicidal Ideation / Accidental Overdose ❑ Blackout(s) = _____ ❑ Medical Treatment/Hospitalization in past 12 months. When? _____Reason? _____

Based on the responses above, consider referral for personal counseling for further evaluation and support.