

Name _____
MR# _____
Date _____
Clinician _____

DBT Client History Survey

So that we may most clearly understand your situation and align you with the most appropriate treatment, please answer the questions below with all honesty in the *present moment*.....how things *actually are in reality* rather than how you might *wish them to be*. For each item, choose the number below which is closest to your experience. **USE THE RATING SCALE BELOW:**

0 = NEVER 1 = SELDOM (once a year) **2 = OCCASSIONALLY** (every few months) **3 = OFTEN** (once a month)
4 = FREQUENTLY (every other week or so) **5 = REGULARLY** (daily up to every other week)

1. I struggle to keep my emotions under control	
2. I don't have any emotions	
3. Other people say that I take things too personally or seriously	
4. When I get angry or sad or worried or fearful, it is very intense.	
5. When I get angry or sad or worried or fearful, it takes a long time for me to calm down to being myself again.	
6. I feel like my emotions run my life.	
7. If only my family, job, school, friends, spouse, etc. would change, my life would be better.	
8. Feelings are bad and wrong.	
9. I can't trust my feelings.	
10. I think that my opinions and thoughts are usually wrong.	
11. I can't do anything good enough.	
12. I am not good enough, strong enough, attractive enough, etc.	
13. Everything is my fault.	
14. No matter how hard I try to make things better, something gets in my way.	
15. My life is a series of crises.	
16. Bad things keep happening to me.	
17. I get into physically or emotionally/verbally abusive relationships.	

DBT Program

Name _____
MR# _____
Date _____
Clinician _____

0 = NEVER 1 = SELDOM (once a year) 2 = OCCASSIONALLY (every few months) 3 = OFTEN (once a month) 4 = FREQUENTLY (every other week or so) 5 = REGULARLY (daily up to every other week)	
18. When I lose something or someone important to me, I should "just get over it".	
19. I should just "face my fear".	
20. I don't like to feel sad.	
21. It's not okay to be angry.	
22. I feel helpless.	
23. I feel like things just keep happening around me.	
24. I need someone else to help me solve my problems.	
25. People think I "have it all together" and it doesn't feel that way to me.	
26. People don't take me seriously when I ask for help.	
27. Other people think I have a problem with: (choose any) drugs, alcohol, food, spending, gambling	
28. I think I have a problem with: (choose any) drugs, alcohol, food, spending, gambling	
29. I have had, in the past, a problem with: (choose any) drugs, alcohol, food, spending, gambling	

Please go on to the next page.

Name _____ MR# _____ Date _____ Clinician _____
--

Please do your best to provide the following information in detail:

LIFETIME SUICIDE ATTEMPTS		REASON (for each event)	METHOD	MEDICAL TREATMENT REQUIRED (Dr, ER, etc)
Date of event	Age			
LIFETIME PSYCHIATRIC HOSPITALIZATIONS		FACILITY	REASON	
Dates	Age			

DBT Program

Name _____
MR# _____
Date _____
Clinician _____

SELF-HARM EPISODES (without intent to die)	AGE 1ST USED METHOD	LAST TIME USED	TOTAL EVENTS	PAST YEAR TOTAL	MEDICAL TREATMENT REQUIRED? If yes, explain
Cutting					
Burning					
Poisons					
Misuse of drugs/alcohol					
Restriction of food intake					
Binge eating					
Purging activities (incl. laxatives)					
Tattoos					
Piercings					
Intentional non-compliance with medical treatment (ie, not taking pain medications, not taking insulin, etc.)					
Hitting self					
Other (explain)					

DBT Program

Name _____
MR# _____
Date _____
Clinician _____

SELF-HARM EPISODES (without intent to die)	AGE 1ST USED METHOD	LAST TIME USED	TOTAL EVENTS	PAST YEAR TOTAL	MEDICAL TREATMENT REQUIRED? If yes, explain
Thought about hurting yourself without the intent to die?					N/A
Thought about killing yourself?					N/A
Had an actual plan to kill yourself?					Why didn't you follow thru?

DBT Program

Name _____ MR# _____ Date _____ Clinician _____
--

TREATMENT HISTORY	DATES	WHAT WAS HELPFUL	WHAT WAS NOT HELPFUL	WHY LEFT TREATMENT
Therapists (psychologist/social worker, pastoral counselor, etc) <i>List names:</i>				
Therapy Groups <i>List names:</i>				
Psychiatrists <i>List names:</i>				

Name _____ MR# _____ Date _____ Clinician _____
--

TREATMENT HISTORY	DATES	WHAT WAS HELPFUL	WHAT WAS NOT HELPFUL	WHY LEFT TREATMENT
Substance Abuse Treatment <i>List names:</i>				
Residential Treatment Programs				
Mental Health <i>List names:</i>				
Substance Abuse <i>List names:</i>				

DBT Program

Name _____
MR# _____
Date _____
Clinician _____

SUBSTANCE USE HISTORY	AGE 1ST USED	LAST TIME USED	TOTAL EVENTS	PAST YEAR TOTAL	CONSEQUENCES OF USE—DUI, arrests, jail time, blackouts, hangover, sexual activity, property damage, relationships, grades, etc
Alcohol					
Marijuana/Hashish					
Cocaine					
"Crack"					
"Meth"					
Heroin					
LSD/acid					
"Speed"					
"Ecstasy"					
Other (explain)					
Prescription drugs (taking meds not prescribed for you, using your own meds differently than prescribed, or for reasons other than prescribed, ie, to 'get high')					
Over the counter medications (taking for reasons other than health conditions, ie, to 'get high' or to 'shut down')					

DBT Program

Name _____
MR# _____
Date _____
Clinician _____

VALUED LIFE AREAS	1 Not at all valued or important to me	2	3	4 Somewhat valued or important to me	5	6	7 Extremely valued or important to me
For each life area below, place an "X" in the box which most closely represents the degree to which you value or consider important that dimension of your life, <u>even if</u> your life is <u>not</u> actually the way you want it to be in that area right now.							
Family of Origin							
Marriage/Significant Others							
Children							
Friends/Social Relationships							
Education/Lifelong learning							
Career/Life work							
Hobbies and Interests, pets							
Sports/Physical Activities							
Spirituality							
Community Involvement							
Health							
Living Environment							
Financial Stability							

Name _____
MR# _____
Date _____
Clinician _____

What would you most like to accomplish in your life?

What would you most like to accomplish in treatment?

What are your concerns about entering DBT treatment?

What are the most important things you would like us to know about you?