COUNTY OF SAN LUIS OBISPO
DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL SELF-ASSESSMENT FOR SERVICES/REFERRAL

As a part of determining the services that may be available to you, please answer the following questions as honestly as you can.

1.	Do you lose time from work or have you gotten into financial difficulties due to drinking or using drugs?	☐ Yes	☐ No
2.	Have people annoyed you by complaining about your drinking or other drug use?	☐ Yes	☐ No
3.	Have you ever had a drink or used drugs in the morning (eye opener) to steady your nerves or to get rid of a hangover?	☐ Yes	☐ No
4.	Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes	☐ No
5.	Have you ever felt you should cut down on your drinking or drug use?	☐ Yes	☐ No

Has a family member, or anyone close to you, done the following:

6.	Thrown or broken things, or frightened you in other ways?	☐ Yes	☐ No
7.	Insulted you or your children, or called you or your children names?	☐ Yes	☐ No
8.	Tried to make decisions for you, including whom you see, where you go or what you wear?	☐ Yes	☐ No
9.	Threatened to hurt himself/herself, you, members of your family, pets, or property that is important to you?	☐ Yes	☐ No
10.	Ever pushed you, shoved you, held you to keep you from leaving a room, punched, kicked, slapped or scratched you?	☐ Yes	☐ No
11.	Threatened to take your children away from you?	☐ Yes	☐ No

During the last six months, have you, or any of your family members done any of the following:

12.	Had any feelings, fears or worries that interfere with your daily tasks?	☐ Yes	☐ No
13.	Had any thoughts or plans of harming yourself or others (examples: pill overdose, injuring yourself or others)?	☐ Yes	☐ No
14.	Had any major changes in your life that have made life unbearable (examples: divorce, death, loss of job, major medical problems)?	☐ Yes	☐ No
15.	Had any significant changes to your daily activities (examples: trouble getting out of bed, bathing, change in sleeping or eating habits, scary dreams, not wanting to be with others)?	☐ Yes	☐ No
16.	Heard voices that others in the same room do not hear, or heard voices that command you to do things you do not want to do?	☐ Yes	☐ No
17.	Had difficulty finding your own job because of emotional problems?	☐ Yes	☐ No
18.	Found it hard to get along with other people when working with them?	☐ Yes	☐ No
19.	Found it hard to remember things (examples: what day of the week it is, important appointments, or focus on discussion)?	☐ Yes	☐ No

Answer the following about Parenting:

20.	Have you ever had problems getting medical care, safe housing or clothing for your children?	☐ Yes	☐ No
21.	Are consistently able to make your children feel good about themselves?	☐ Yes	☐ No
22.	Do you feel overwhelmed as a parent dealing with your children's:	☐ Yes	☐ No
	☐ Behavior ☐ Emotional ☐ Discipline ☐ Other _____?(Mark all boxes that apply.)		
23.	Are you willing to access Parent Education through Community Resources?	☐ Yes	☐ No
24.	Do any of your children have any special needs due to: (check all that apply)	☐ Yes	☐ No
	☐ Medical Problems ☐ Developmental Disability ☐ Mental Health ☐ Delinquency		

We ask these questions of everyone because we all have fears, worries or troubles that may lead to emotional problems, drug abuse or alcohol abuse. These questions will help us decide if talking with a counselor might help you and your family. You may ask to speak with a counselor even if you indicated no concerns above. Would you like to speak to a counselor: ☐ **Yes** ☐ **No**

Participant's Signature: _____ Date: _____

County Use Section

Participant's Name: _____ Case Number: _____ Date: _____

Referring Worker's Name: _____ Worker Number: _____

Date: _____ Worker's Phone Number: _____