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ADULT ASSESSMENT

Client's Name _____ Today's Date _____

Address _____ City, State, Zip _____

Phones with Area Code: Cell _____ OK to leave a message/text? Y N

Home _____ OK to leave a message/text? Y N

Work _____ OK to leave a message/text? Y N

Email address(es)_____ OK to email? Y N

Emergency Contact Name _____ Phones: _____

Client's Date of Birth _____ Age _____ If Insurance, Insured's Date of Birth _____ Age _____

Highest Education _____ in what?_____

Employer _____ How long? _____ Position _____

Military Experience _____ Ethnic/Culture/Religious Information _____

Current or potential legal proceedings _____

Marital/Relationship Status _____ How long? _____ Partner's Name _____ Age _____

Rate your relationship satisfaction: 0 (terrible) - 10 (fantastic) Currently _____ Best _____Worst_____

Names/Ages of all children living in the home:

_____

_____

Names/Ages of all children living outside the home & why:

_____

Names/Ages/Relationship of others living in the home:

_____

Names/Ages of your other *significant* relationships (i.e. boyfriend, Mom, father, steps, siblings, grandparents, etc):

_____

_____

What is your birth order _____ of _____ Is there a family history of mental health issues? Y N

Have you experienced abuse or a traumatic event? Y N If so, what? _____

_____

Have you been hospitalized for psychiatric or substance abuse issues? Y N When/Where? _____

Have you seen a counselor before? Y N When? _____ for What? _____

What helped?

_____

What didn't?

_____

List your health problems/diagnoses:

_____

List **all** your current medications/how long taken:

_____

_____

List any supplements/OTC & for what:

_____

Please indicate which of these you currently engage in & how often (be honest!):

Alcohol _____ servings per _____ Tobacco _____ per _____ Marijuana _____ per _____ Drugs _____ per _____

RX not prescribed for me _____ per _____ Gaming _____ hours per _____

Pornography _____ hours per _____ Gambling _____ per _____ Social Media _____ hours per _____

Substances/addictive behaviors used in the past & when:

_____

Addiction concerns for Self? Y N Others? Y N Who/What? _____

List Physicians & when last seen

_____

_____

Allergies? Y N What? _____ Date of last Physical _____

If/When you diet, what method do you use?

_____

Are you reasonably happy with your body? Y N Do you intentionally hurt yourself? Y N How? _____

_____

How often do you exercise? _____ per _____ Health concerns in significant others _____

Rate your sexual satisfaction: 0 (terrible) - 10 (fantastic) Currently _____ Best _____ Worst_____ Concerns in self or partner? _____

What are your hobbies/affinities?

_____

About how many friends do you have _____ Are you happy with that? Y N Any Drama? _____

_____

_____

Who is in your 'Support System'

_____

Please indicate the following concerns, given *what is normal for you*:

Now	Past	
o	o	Change in appetite More Less _____
o	o	Change in sleep More Less _____
o	o	Change in desire for sex More Less _____
o	o	Change in spending habits More Less _____
o	o	Change in weight More Less _____
o	o	Change in energy level More Less _____
o	o	Change in overall mood _____
o	o	Thoughts of hurting/killing self If so, how & when? _____
o	o	Thoughts of hurting/killing others If so, who, how & when? _____
o	o	Unusual thoughts What? _____
o	o	Unusual behaviors What? _____
o	o	Worries What? _____
o	o	Lack of pleasure from things you used to enjoy What? _____

In the last 12 months, have you experienced a:

Marriage Separation Divorce/Break up Birth Death Job change Move Military Deployment
Bankruptcy Significant Illness/Injury Natural Disaster/Accident Graduation/Promotion Loss

List of Symptoms/Concerns. Feel free to describe further:

- ☐ Abortion
- ☐ Abuse-emotional
- ☐ Abuse-neglect
- ☐ Abuse-physical
- ☐ Abuse-sexual
- ☐ Aggression
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention Problems
- ☐ Blended Family
- ☐ Body Image
- ☐ Boredom
- ☐ Career concerns
- ☐ Childhood issues (your own)
- ☐ Children-care
- ☐ Children-custody
- ☐ Children-management
- ☐ Choices you have made
- ☐ Codependence
- ☐ Compulsions
- ☐ Concentration Problems
- ☐ Confusion
- ☐ Crying
- ☐ Death
- ☐ Decision making
- ☐ Delusions (beliefs that are not true/real)
- ☐ Dependence
- ☐ Depression
- ☐ Distractibility
- ☐ Divorce
- ☐ Eating-making myself vomit or using laxatives
- ☐ Eating-over eating
- ☐ Eating-under eating
- ☐ Employment problems
- ☐ Employment-lack of
- ☐ Employment-overdoing
- ☐ Employment-termination
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue
- ☐ Fears
- ☐ Feelings-Mixed
- ☐ Feelings-Intense
- ☐ Feelings-Overwhelming
- ☐ Financial troubles
- ☐ Friendship problems
- ☐ Gambling
- ☐ Goals not being met
- ☐ Grieving
- ☐ Guilt
- ☐ Hostility
- ☐ Hallucinations, seeing or hearing things not there
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Inhibitions
- ☐ Interpersonal conflicts
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment problems
- ☐ Laziness
- ☐ Learning differences
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Losses
- ☐ Low energy
- ☐ Low frustration tolerance
- ☐ Marital coldness
- ☐ Marital conflict
- ☐ Marital distance
- ☐ Marital infidelity/affairs, whether acted on or not
- ☐ Medical concerns
- ☐ Memory problems
- ☐ Menopause
- ☐ Miscarriage
- ☐ Mood swings
- ☐ Motivation
- ☐ Obsessions
- ☐ Outbursts
- ☐ Oversensitive to criticism
- ☐ Oversensitive to rejection
- ☐ Pain
- ☐ Panic or anxiety attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Phobias
- ☐ Physical problems
- ☐ PMS
- ☐ Poor self-care
- ☐ Procrastination
- ☐ Relationship problems
- ☐ Relaxation ability
- ☐ Remarriage
- ☐ Risk taking
- ☐ Sadness
- ☐ School problems
- ☐ Self-centeredness
- ☐ Self-control
- ☐ Self-esteem
- ☐ Self-neglect
- ☐ Separation
- ☐ Sexual-conflicts
- ☐ Sexual-desire differences
- ☐ Sexual-dysfunctions
- ☐ Sexual-orientation
- ☐ Shyness
- ☐ Sleep-falling asleep
- ☐ Sleep-staying asleep
- ☐ Sleep-nightmares
- ☐ Special needs child
- ☐ Step-parenting
- ☐ Stress
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Thoughts-disorganized
- ☐ Thoughts-circular
- ☐ Violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating

Describe any other concerns and/or ways that I can help:

_____

_____

_____

Who referred you? _____ Can I let them know that you came? Y N

Whew! Thank you for the time you took to tell me about yourself. Now, we can work together to identify what you need, help you get unstuck, develop coping strategies and make effective changes. Let's get started!

_____

Signature