Initial Assessment - Adult (17 and older)

Date: _____

Name: _____ Cell Phone: _____

Age: _____ Email: _____

What are your strengths, interests, and/or hobbies? _____

_____

_____

What are the concerns/issues that bring you to therapy today? _____

_____

_____

_____

When did these symptoms begin?_____

How frequently do these symptoms occur? _____

How much do these symptoms impact your daily routine/functioning? (1-no impact; 10-severe impact)

1 2 3 4 5 6 7 8 9 10

What strategies have you tried to address these concerns? _____

_____

_____

What changes are you hoping to see in therapy? _____

_____

How hopeful are you about seeing improvement in yourself?

1 - Not at all hopeful 2 - a little hopeful 3 - somewhat hopeful 4 - very hopeful

If you are not hopeful, why not? _____

_____

Marital Satus: Single Separated Divorced Married Cohabitating

What is your spouse/partner's name? _____

How long have you been married/cohabitating? _____

How would you describe your current relationship? Good Fair Poor

Are you sexually active? Yes No

Are you pregnant? Yes No

Please list any children you have, including age and who they live with:

Please list everyone currently living in the home and their relationship to you: _____

_____

Pleast list any psychiatrists, psychologists or therapists you have seen in the past.

_____

_____

Have you had any psychiatric hospitalizations? Yes No

Please list your diagnoses, dates and locations of treatment: _____

_____

_____

Have you ever thought about suicide? Yes No

Did you have a plan? Yes No

Have you ever attempted suicide? Yes No If yes, when? _____

Current Medications Prescribed	Dosage	Frequency	Improvement Noticed

Past Psychiatric History

Prior out patient alcohol/substance abuse treatment?	yes	no
History of non-suicidal injury (scratching, cutting, burning)?	yes	no
Method of self harm:		
Prior History of Aggression or Violence?	yes	no
Aggression towards:		
Legal charges stemming from aggression:	yes	no
Incarceration stemming from aggression:	yes	no

Legal Issues

Prior difficulties with the legal system ever?	yes	no
Prior incarcerated	yes	no
Current legal issues?	yes	no
COMMENTS/Explanation of Positive Responses		

Sleep and Current Functioning

Do you have trouble falling asleep? Yes No

Do you have any trouble staying asleep? Yes No

Usual bedtime: _____ Usual Wake Time: _____

Do you have any difficulties with snoring or other sleep disruptions? _____

Have you experienced any of the following recently:			**If yes, how long?**
Little interest or pleasure in doing things	yes	no	
Feeling bad about yourself or that you are letting yourself or others down	yes	no	
Trouble concentrating or being easily distracted	yes	no	
An increase or decrease in your energy level	yes	no	
Poor appetite or overeating	yes	no	
Recent weight gain/weight loss	yes	no	
Feelings of hopelessness or helplessness	yes	no	
Feeling anxious, worried or nervous	yes	no	
Hearing voices or seeing things that are not really there	yes	no	

Medical History

Who is your Primary Care Physician? _____

Date of last visit _____

Do you have other physicians? _____

Please circle all that apply: High/Low Blood Pressure Heart Disease Diabetes Gout Asthma Cancer

Emphysema Hay Fever/Sinusitis Bronchitis Hives Pleurisy Thyroid Problems Kidney Stones

Frequent Urinary Track Infections/Bladder Infections Hepatitis Arthritis Ulcers Eczema HIV/AIDS

Dizziness/Fainting History of any STDs Bleeding Tendencies History of Head Injury Seizures

Loss of Counsciousness Other: _____

Do you have any known allergies? yes no

If yes please explain: _____

Do you currently smoke? yes no for _____ years

Do you drink alcohol? yes no

How much, how often? _____

Have you ever felt you might have a problem with alcohol? yes no

Has anyone ever told you that you had a problem with alcohol? yes no

If yes, please explain: _____

_____

Please list any medical or mental health problems in your family (parents, siblings, grandparents, aunts/uncles):

_____

_____

_____

Were there any problems or complications with your birth? yes no

Please list any medical hospitalizations (include date and reason for hospitalization):

_____

_____

_____

Please list any recent blood work or other testing you have undergone (indicate where/when):

_____

_____

Psychiatric Social History

Were you adopted? Yes No

Relationship status of biological parents: Married Divorced Separated Never Married

Loss of parent by death prior to age 18? Yes No

Would you describe your childhood as: Happy Average Unhappy

How would you describe your socio-economic status growing up? Lower Middle Upper

During childhood, did you experience any

Emotional abuse? Yes No

Physical abuse? Yes No

Sexual abuse? Yes No

Have you ever witnessed violence or been involved in a violent episode? Yes No

Comments/Explanation of Positive Responses:

Education & Work

Highest Grade Completed: _____

Did you experience difficulty in school? Yes No

Did you receive any Special Education Services? Yes No

If yes, please explain: _____

_____

Do you work? Yes No Hours per week? _____

Where? _____

Job Title: _____

How long have you been at this job? _____

How many jobs have you had in the last 5 years? _____

Are you satisfied with your current work? Yes No

What problems or stressors have you had at work? _____

_____

_____

Do you have current finanical stressors? _____

_____

Are you currently on Disability? Yes No

Are you currently seeking Disability? Yes No

Are you now or have you ever been a member of the Armed Services?

Yes, active Yes, inactive Yes, retired No

If so, which branch? _____

Please provide any current or past use of substances			**If yes, how much how often?**
Alcohol: (beer, wine, liquor)	yes	no	
Cannabinoids: (marijuana, hashish)	yes	no	
Opioids and Morphine Derivatives: (codeine, morphine, Heroin, opium)	yes	no	
Stimulants: (cocaine, amphetamines, methamphetamines)	yes	no	
Club Drugs: (MDMA, GHB, Flunitrazepam)	yes	no	
Dissociative Drugs: (Ketamine, PCP, Dextromethorphan Salvia)	yes	no	
Depressants: (barbiturates, benzodiazepines)	yes	no	
Hallucinogens: (LSD, Psilocybin, Mescaline)	yes	no	
Anabolic steroids: (depo-testosterone, anadrol)	yes	no	
Inhalants: (huffing, glue, solvents etc)	yes	no	
Intravenous drug use	yes	no	
Have you had any difficulties with any of the following issues related to substance use?	yes	no	
TOLERENCE (increased amount of substance required to obtain initial effect of the drug)	yes	no	
WITHDRAWAL (symptoms of physiologic or psychological distress upon stopping or reducing the amount of drug used)	yes	no	
consumption exceeds intented amount	yes	no	
efforts to reduce/control consumption	yes	no	
excessive time spent related to substance use and leading to disruption of daily functioning	yes	no	