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Adult Initial Assessment

Please fill out this biographical background form as completely as possible. All information is confidential as outlined in the Office Policy form. If you do not desire to answer any question, merely write "Do not care to answer."

NAME: _____ M/F: _____ DATE: _____

DATE OF BIRTH: _____ PLACE: _____ AGE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SOCIAL SECURITY #: _____ E-MAIL: _____

TELEPHONE: H: _____ W: _____ CELL: _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

MEDICAL DOCTOR/S (name /phone): _____

REFERRAL SOURCE: _____

May I inform this person that you have consulted with me? _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PRESENTING PROBLEM (be as specific as you can: When did it start, how does it affect you.)

CURRENT MARITAL STATUS: _____ Live with someone: _____ Name: _____ #Yrs: _____

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e. friendly, distant, physically/emotionally abusive, loving, hostile):

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

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CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. _____
2. _____
3. _____
4. _____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father: _____

Mother: _____

Step-parents: _____

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time:

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1. _____
2. _____
3. _____
4. _____
5. _____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

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FAMILY MEDICAL AND PSYCHIATRIC HISTORY (Describe any physical or mental illness that runs in the family including depression or suicide):

FAMILY HISTORY OF ALCOHOL/DRUG PROBLEMS (Describe any abuse of substances that runs in the family):

FAMILY HISTORY OF VIOLENCE OR EMOTIONAL/PHYSICAL ABUSE (Towards you or other members of your family):

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning.end), estimated no. of sessions, name,degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1.

2.

**** USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS****

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

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Prescription Drugs:

Type	Amount	Frequency	Date last used
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PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

Coffee (# _____ cups/daily)

Cigarettes (# _____ per day)

Alcohol (# _____ drinks/daily _____ or weekly _____) Date last drank: _____

Street drugs (Type): _____ Frequency: _____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc)

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

Please indicate how the following symptoms/problems/complaints are effecting you:

1)Little effect 2)Some effect 3)Much effect 4)Significant effect

(Leave blank if no effect)

- | | |
|--|---|
| <input type="checkbox"/> Eating habits/Appetite: eating more,
eating less | <input type="checkbox"/> Spending sprees |
| <input type="checkbox"/> weight change; amount <input type="checkbox"/> | <input type="checkbox"/> Rapid heartbeat |
| <input type="checkbox"/> binge; purge | <input type="checkbox"/> Phobia |
| <input type="checkbox"/> Sleep: Trouble falling asleep; | <input type="checkbox"/> Sweating |
| Trouble staying asleep; | <input type="checkbox"/> Trouble Breathing |
| Trouble waking up; | <input type="checkbox"/> Flashbacks of traumatic events |
| Average # hours sleep <input type="checkbox"/> | <input type="checkbox"/> Nightmares |
| #Naps <input type="checkbox"/> | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Decreased energy/Fatigue | <input type="checkbox"/> Impulse control - hyperactive |
| <input type="checkbox"/> Sexual functioning | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Loss of interest in activities | <input type="checkbox"/> Anxious/nervous |
| <input type="checkbox"/> Tearfulness | <input type="checkbox"/> Worry/fear |
| <input type="checkbox"/> Hopelessness/Helplessness | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Decreased attention span | <input type="checkbox"/> Seeing things that are not there |
| <input type="checkbox"/> Inattentive/Distractible | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Memory: Long term;short term | <input type="checkbox"/> Anger outbursts |
| <input type="checkbox"/> Difficulty planning ahead | <input type="checkbox"/> Panic attacks - Frequency |

Rate how the problems/symptoms/complaints are impacting areas of functioning:

(Leave blank if no effect) 1)Mild 2)Moderate 3)Severe

- | | |
|--|---|
| <input type="checkbox"/> Marriage/Relationship | <input type="checkbox"/> Clubs/Group memberships |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Family | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Friendships | <input type="checkbox"/> Attending to daily living activities
(shower, grooming, self care, etc) |
| <input type="checkbox"/> Financial situation | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Physical health | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Social interests | |
| <input type="checkbox"/> Leisure activities | |

What gives you most joy or pleasure in your life:

What are your main worries and fears:

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What do you identify as your strengths:

What do you identify as your weaknesses:

What are your goals for treatment:

Please add anything in the space provided any other information you would like me to know about you and your situation.

Patient Name: _____ **Date:** _____

Patient Signature: _____