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ASSESSMENT AND HISTORY INFORMATION-ADULT

Name:_____DATE:_____

Have you ever been treated by a psychiatrist? ____YES____NO

If "YES" name/agency of psychiatrist and dates of treatment:

_____

Have you ever been treated by a counselor/therapist?____YES____NO

If "YES" name/agency of counselor/therapist and dates of treatment:

_____

Physician:_____

Current medication:_____

Has client been exposed to trauma?____YES____NO

Any mental health problems on fathers/mothers side of family?____YES____NO

If "YES", please indicate who and what diagnosis:

_____

Briefly describe reasons for seeking counseling services:

_____

_____

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_____

Briefly describe what has been tried to improve the situation:

_____

_____

_____

Please place a number that best corresponds to the issue listed below:

NOT APPLICABLE NOT VERY SERIOUS SERIOUS VERY SERIOUS

1 2 3 4 5 6 7 8

___Abuse-physical	___Abuse-sexual	___Abuse-emotional
___Abuse-neglect	___Aggression-violence	___Anger, hostility, irritability
___Anxiety, nervousness	___Attention, distraction	___Confusion
___Compulsions	___Cruelty to animals	___Crying, sadness
___Indecision	___Delusions (false ideas)	___Depression
___Divorce, seperation	___Eating problems	___Grieving
___Guilt	___Headaches	___Impulsiveness
___Loss of Control	___Unmotivated	___Memory problems
___Mood swings	___Obsession/compulsion	___Panic/Anxiety attacks
___School problems	___Low self-esteem	___Sleep problems
___High stress	___Suicidal thoughts	___Temper problems

OTHER:_____

Any other information not included on this form that is pertinent for therapist to know:

_____

_____

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