ADULT INITIAL ASSESSMENT

Client Name: _____ Date: _____
Other attendees/relationship: _____
_____
Client DOB: _____ Age:_____ Gender: __ Preferred phone number: _____
Occupation: _____ Employer: _____

1. What brings you here today?

2. Any previous counseling? If yes, where and when.

3. Partner Relationships/Family
Marital history (# of marriages, dates, how they ended, other long-term romantic relationships)

Current relationship status. Single, married, divorced, widowed.

Adults and children in the home with ages:

Parents/siblings. Names and ages. Indicate if deceased.

4. Health
Last physical exam _____ Doctor's name _____
Medical history (illnesses, accidents, medications, current health status)

Any Medications?

Alcohol use. Drinks per week_____ Month_____
Cigarette use. Yes or No

Family health history:

Family mental health history (depression, anxiety, ADHD, suicide, etc):

5. Personal
Any changes or losses in your life?

Employment history:

Highest education level: Military service:

Any legal issues?

Abuse: Yes or No. Physical, Emotional or Sexual

Any traumatic events (tornadoes, violence, accidents)?

Who/what is your support system?

What are your strengths?

What are you goals for coming here? What would you like to see change in your life?

Current Health Concerns: Please circle where you think your child may have a problem.
Headaches Depression *Breathing* Anger/Temper *Circulation* Frequent Mood Changes *Indecision*
Bowel Function *Self Concept* Tiredness *Guilt* Urinary Function *Suicide Ideas* Sexuality
Problems with Relatives *Smoking* Alcohol Use *Memory* Weight loss/gain *Interpersonal Relations*
Stomach Problems Menstrual Cycle *Parenting Concerns* School Problems *Work/Job Issues*
Marital Issues *Phobias* Concentration *Attention* Eating/Appetite *Anxiety/Worry* Drug Use *Chronic Pain*
Joint/Muscle Function Skin Condition *Sleep Disturbance* Menopause *Other*_____

Anything else important for us to know in order to help you?

Thank you!!