ADULT INITIAL ASSESSMENT

Client Name:	ationship:		Date:
Client DOB:	Age:	Gender:	Preferred phone number:Employer:
1. What brings you	ı here today?	•	
2. Any previous cou	inseling? If yes	s, where and wh	hen.
3. Partner Relation Marital history (# of r			nded, other long-term romantic relationships)
Current relationship	status. Single	e, married, divor	rced, widowed.
Adults and children i	n the home wi	ith ages:	
Parents/siblings. Na	ames and ages	s. Indicate if ded	ceased.
4. Health Last physical exam Medical history (illne	Desses, acciden	octor's name _ ts, medications,	, current health status)
Any Medications?			
Alcohol use. Drinks Cigarette use. Yes		Month	
Family health history	/:.		
Family mental health	n history (depr	ession, anxiety,	, ADHD, suicide, etc):

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?					

5. Personal

Thank you!!

Any changes or losses in your life?