Life's Light and Hope, PLLC
Sara E. Collins, LMSW
Phone: (734) 582-4294
Text: (734) 265-0554
Fax: (734) 468-0106

ADULT ASSESSMENT AND PERSONAL HISTORY

Client Name: ______________________________________ DOB: ________________ Age: _____

Street Address: ____

City: __________________ State: __________ Zip Code: ____________________________

Home Phone: ____

Cell Phone: ____

Work Phone: ____

Email Address: ____

CULTURAL/ETHNIC/RACIAL BACKGROUND (optional)

Do you belong or identify with a cultural, ethnic, or racial group? Please describe: ___________

____

____

SPIRITUAL/RELIGIOUS BACKGROUND

Religious Preference: ____

Do you consider yourself to be a spiritual person (Please explain) _________________________?

____

How were you referred to us? ____

Reason for seeking treatment: ____

____

____

What are your treatment goals? ____

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Current symptoms checklist (Check any symptoms that are present past or present)

( ) Depressed mood	**( ) Racing Thoughts**	**( ) Excessive Worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Increased risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/Forgetfulness	**( ) Decreased need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) Excessive guilt**
( ) Increased irritability	**( ) Fatigue**	**( ) Crying spells**
( ) Decreased libido	**( ) ______________________**	**( ) ______________**

When did these symptoms start? ____

How frequently do you experience these symptoms? ___________________________________

How intense are these symptoms? Severe Mild Moderate

Have you ever been hospitalized, psychiatric or non-psychiatric (location and date)?

____

____

Have you been diagnosed with a mental illness before? If so, what was the diagnosis? _________

____

SUICIDE RISK ASSESSMENT

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If yes, please answer the following. If NO, please skip and continue to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? ____

When was the last time that you had thoughts of dying? _______________________________

Has anything happened recently to make you feel this way? ___________________________

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On a scale of 1 to 10 (10 being the strongest), how strong is your desire to kill yourself currently?

Would anything make it better? ____

Have you ever thought about how you would kill yourself? ______________________________

Is the method you would use readily accessible? _______________________________________

Have you planned a time for this? ____

Is there anything that would stop you from killing yourself? _______________________________

Do you feel hopeless/ worthless? ____

Have you ever tried to kill or harm yourself before? _____________________________________

Do you have access to guns? ____

TRAUMA HISTORY

Do you have a history of being abused emotionally, sexually, physically, or by neglect?
( ) Yes ( ) No

What was the nature of the trauma? ____

____

When did this trauma occur? ____

Who perpetrated the trauma? ____

MEDICAL HISTORY/ MEDICATIONS

List all current prescriptions, dosage, and how often you take them (If none, write none)

____

____

____

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Current over-the-counter medications or supplements: ________________________________

____

Current medical problems: ____

____

SUBSTANCE USE

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? ____

____

If yes, where were you treated and when? ____

____

FAMILY BACKGROUND and CHILDHOOD HISTORY

Where did you grow up? ____

Please list your siblings and ages: ____

____

____

Did your parents divorce when you were a child? ( ) Yes ( ) No

If so, how old were you they when they divorced? ___________________________________

If your parents divorced with whom did you live? ____________________________________

Describe your mother and your relationship with her: ________________________________

____

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Describe your father and your relationship with him: ________________________________

____

RELATIONSHIP HISTORY and CURRENT FAMILY:

Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed ( ) Partnered

How long?

If not married, are you currently in a relationship? ( ) Yes ( ) No

How would you describe your sexual orientation? (optional)

( ) Straight/Heterosexual ( ) Lesbian/Gay/Homosexual ( ) Bisexual
( ) Transsexual ( ) Unsure/Questioning ( ) Asexual
( ) Other ( ) Prefer not to answer

Describe your relationship with your spouse or significant other: ________________________

____

Do you have any children? Please list names and ages: ____________________________

____

____

Described your relationship with your children: ____________________________________

____

____

List everyone that lives in the home with your family: ________________________________

____

____

Have you recently experienced the loss of a family member? ___________________________

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SOCIAL HISTORY

Who do you consider to be your social supports? ____

____

What is your relationship with these supports? ____

____

How would you describe these relationships? ____

____

Social time is usually spent: ( ) Alone ( ) Immediate Family ( ) Peers

Please describe: ____

____

EDUCATIONAL HISTORY

Highest Grade Completed ___________ Where? ___________________________________

Did you attend college? ( ) Yes( ) No Where? ____

What is your highest degree? ____

OCCUPATIONAL HISTORY

Are you currently: ( ) Working ( ) Student ( ) Unemployed
( ) Disabled ( ) Retired

How long have you been in your present position? _____________________________________

What is/was your occupation? ____

Where do you work? ____

Have you ever served in the military? ( ) Yes ( ) No

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If so, what branch and when? ____

Honorable discharge ( ) Yes ( ) No

Other: ____

LEGAL HISTORY

Have you ever been arrested? ____

Do you have any pending legal problems? ____

Are you presently on probation or parole? ( ) Yes ( ) No

What is the charge? ____

____

What are your strengths? ____

____

What are your struggles? ____

____

Is there anything else that you would like to share? ___________________________________

____

____

____

____

____

____

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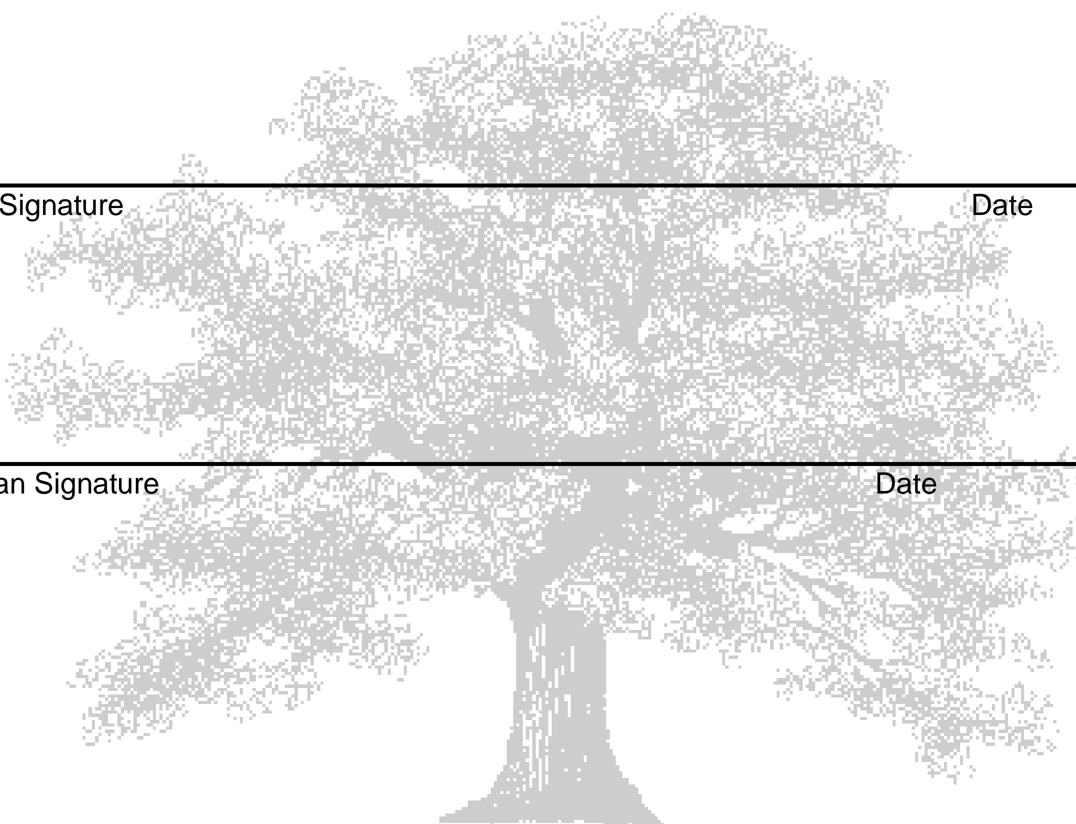

Emergency Contact Telephone number

Client Signature Date

Clinician Signature Date