

Adult Assessment - Background information Form

** indicates a required field*

Before your assessment appointment, I would like to get some background information, Please answer the following information to the best of your ability. Thank you! Bethany Zoeller - Insights Assessment & Counseling

*** Name:**

Name you prefer to be called:

*** Address:**

Mailing address (if different)

*** Race:**

- American Indian
- Asian
- Black/African American
- Hispanic/Latino
- White
- Prefer not to answer

Gender

Mental Health

*** Within the last 30 days have you experienced any of the following symptoms? Check all that apply**

- Hopelessness/Helplessness
- Extreme Fatigue/No Energy
- Poor Memory
- Change in eating habits (eating too much or too little)
- Thoughts of suicide
- Panic Attack
- Hearing things others cannot hear
- Seeing things others cannot see
- Feeling that people are out to get you or watching you
- Anxious in large crowds

*** Are you a survivor of trauma?**

- Yes
- No

Social History

*** Marital Status**

- Never Married
- Married
- Widowed
- Divorced
- Separated

*** Do you have children?**

- Yes
 No

*** Who do you currently reside with?**

*** What is your relationship like with your parents? Select all that apply**

- Good
 Fair
 Poor
 Close
 Stressful
 Distant
 Complicated
 Not Applicable

*** Do you have any close friends? (People you interact frequently and would turn to when you need support?)**

- yes
 no

*** What activities do you do for fun?**

Education

*** What is the highest grade you have completed in school?**

- No Education
- K-5th grade
- 6-8th grade
- 9-12 grade
- GED
- College Degree
- Masters Degree

Names of schools attended

Elementary School

Middle School

High School

College(s)

*** Any history of grade retention (being held back)? If yes, what grade?**

Did you ever receive special education services (IEP services) or 504 accommodations while enrolled in school?

- Yes
- No

If Yes, please describe

Are you currently enrolled in a school or training program? If yes, please describe.

Substance Use

*** In the past 6 months, have you used any of the following:**

- Alcohol
- Tobacco
- Marijuana
- Non-prescribed medication
- Other controlled substance
- None of the above

Legal History

*** Have you ever been arrested? (If no, please skip to the Work Section)**

- Yes
- No

If yes, how many times?

If yes, what were you arrested for?

Are you currently or have you ever been on probation or parole?

Work

*** Are you currently employed?**

- Yes
- No

If yes, please provide input on current employment

Current Employer & Job Title

How long have you been employed in this position?

Do you get along well with your coworkers/boss?

If no, please provide information on any previous jobs.

Previous employer and job title

Estimated dates of employment

Previous employer & job title

Estimated dates of employment

Health

*** How would you describe your current overall health?**

- Good
- Fair
- Poor

Do you have any past or current medical/surgical problems? If yes, please describe.

Are you currently prescribed any medications? If yes, please provide the name and dosage.

*** Any family history of (select all that apply to parents or siblings)**

- Alcohol/Substance Abuse
- History of completed suicide
- Depression
- Schizophrenia
- Bipolar Disorder
- Attention Deficit Hyperactivity Disorder (ADHD or ADD)
- Anxiety
- Learning Disorders
- Speech disorders
- Autism Spectrum Disorder
- None

How many hours a sleep do you get on average per night?

Please indicate if you struggle with any of the following

- Difficulty falling asleep
- Difficulty staying asleep
- Feeling exhausted regardless of sleep quantity