SANTA ROSA COUNSELING CENTER

ADULT PSYCHOSOCIAL ASSESSMENT

The following necessary information will help make your first session most productive. Please ensure that all therapy participants (18 years & older) sign a Patient Agreement form. If you are court-mandated to receive counseling, please be prepared to provide the court order or case plan. Please bring all documents to the first session.
Please **PRINT** and fill out this form **COMPLETELY**.

Date of assessment: _____

DEMOGRAPHICS

Last Name _____ First _____ Middle _____

Date of Birth _____ Age _____ ID / Driver License Number _____ State _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone (Cell) _____ (Home) _____ (Work) _____ Email _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Partnered ☐ Widowed

Gender: ☐ Male ☐ Female

PERSONAL HISTORY

Why are you seeking treatment at this time and what do you hope to gain from counseling?

_____

_____

Have you had any of the problematic experiences of the following within the past 90 days? (Check all that apply)

- ☐ Anxiety / Panic
- ☐ Racing thoughts
- ☐ PTSD / Trauma
- ☐ Obsessive / Intrusive thoughts
- ☐ Concentration / Focus problems
- ☐ Depression
- ☐ Mood swings
- ☐ Paranoia / Delusions
- ☐ Hallucinations
- ☐ Psychosis
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Self injury
- ☐ Thoughts of harming others
- ☐ Abuse / Violence
- ☐ Poor sleep patterns
- ☐ Addiction / Dependency
- ☐ Employment / Academic
- ☐ Legal
- ☐ Other _____
- ☐ Relationship problems
- ☐ Extramarital affair
- ☐ Family / Parenting conflict
- ☐ Grief / Death
- ☐ Developmental delay
- ☐ Physical / Medical problems
- ☐ Weight Gain / Loss
- ☐ Hospitalization

PSYCHIATRIC HISTORY

Starting with most current, please list current and past mental / behavioral health medications:

Medication	Dosage	Reason	Doctor / ARNP	Still taking?

Have you ever been in counseling before? ☐ Yes ☐ No

Have you ever been admitted into a hospital for mental / behavioral health? ☐ Yes ☐ No

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

CLINICAL NOTES

Santa Rosa Counseling Center
5642 Jones Street, Milton, Florida 32570
Office (850) 626-7779 Fax (850) 626-7171
santarosacounselingcenter.com

SANTA ROSA COUNSELING CENTER

MEDICAL

Who is your primary care physician? _____ ☐ Do not have

List any medical symptoms and medications: _____

Does your physical pain cause mental health issues?	☐ Yes	☐ No
Have you recently experienced any appetite changes?	☐ Yes	☐ No
Have you recently had a gain or loss of over 10 lbs.?	☐ Yes	☐ No

Describe your sleep patterns: _____

EDUCATIONAL / OCCUPATIONAL HISTORY

What is your highest level of education completed? _____ ☐ Current student

Where are you presently employed? _____ ☐ Military history

LEGAL HISTORY

Have you been arrested in the past two years?	☐ Yes	☐ No
Are you involved with a DCF/FFN case or investigation?	☐ Yes	☐ No
Are you court ordered for services?	☐ Yes	☐ No

SUBSTANCE USE

Describe your history of substance use below, even casual or recreational experiences:

_____

_____

FAMILY HISTORY

Describe your relationship with who you were **raised by** growing up until now:

_____

Describe your relationship with your **siblings** growing up until now: (with names and ages) ☐ Not applicable

_____

_____

Describe your relationship with your **spouse or partner**: (with name and age) ☐ Not applicable

_____

Describe your relationship with your **children**: (with names and ages) ☐ Not applicable

_____

SOCIAL / SUPPORT SYSTEM

Who is your support system? _____

Describe your leisure/recreational activities: _____

Describe activities/relationships you have recently started or stopped: _____

_____

Patient Name Patient Signature

PROVIDER SIGNATURE

_____

☐ K. ALESIA WILLIS, LMFT, LMHC	☐ SUE GESSLER, LMHC	☐ BRANDY INGRAM, LCSW
☐ BRIAN E. WILLIS, LMHC	☐ BRITTANY PAQUETTE, LMHC	☐ ROBERT FILLINGIM, LMHC
☐ MELISSA D. GARNER, LMHC	☐ BREE CONKLIN, LCSW	☐ JACOB DAVIS, M.S.

STAFF NOTES