ADULT SELF-ASSESSMENT

Today's Date: _________________ Referred From: ___________________

Name of Client ________________________ DOB _______________ Age ____ Gender F M

Address _____________________________ City __________________ State ______ Zip _____________

Home Phone __________________ Work Phone ___________________ Cell _____________________

Leave message: Home # Y N Work # Y N Cell # Y ____ N _____

Email Address: ____

Primary Health Insurance Company: ____________ ID: ____________________ Group #: _____________

Provider Services Tel # (back of card) ____________________ **Subscriber Name**: ___________________

Subscriber DOB: ____________ Relationship to Client: _________ Subscriber Employer: ________________

Secondary Health Insurance Company: _______________ ID: __________________ Group #: ___________

Subscriber Name: ____________________ Subscriber DOB: ____________ Relationship to Client: __________

In Case of Emergency, notify: _________________________ Relationship to Client: ____________________

Tel # ________________Cell # ________________ Is person aware client is seeking services? Y ____N ____

Please note that by providing Lisa Alber, LICSW with this emergency information, you are giving permission to contact this person in an emergency.

Psychiatric History:

Have you been in therapy before? Yes No

List **current and/or previous** therapist:

Therapist ___________________ Dates of Treatment: ____________ Symptoms ______________________

Current psychiatric medications: ____

Prescriber of these medications: __________________________ Tel #: _________________________

Have you been hospitalized for psychiatric symptoms? Yes No

Date(s) of Hospitalization: _______________ Hospital: ___________________ Reason: _________________

Why have you decided to seek counseling at this time?

____

What are your goals of therapy?

____

Place a ☑ next to any current symptom.

☑		☑		☑		☑	
	Depressed Mood		Anxious		Obsessive Thoughts		Ignore Rules
	Low Self-Esteem		Irritable		Compulsive Behaviors		Make Careless Mistakes
	Low Energy/Fatigue		Muscle Tension		Fear of Social Situations		Difficulty Sustaining Attention
	Poor Concentration		Worry		Racing Thoughts		Often Lose Things/Forgetful
	Hopelessness		Stress		Over Spending		Easily Distracted
	Worthlessness		Heart Racing/Chest Pain		Gambling		Binging/Purging
	Sadness/Emptiness		Feel Dizzy/Lightheaded		Frequent Mood Swings		Fear of Gaining Weight
	Insomnia		Sweating		More Energy Than Usual		Use Drugs
	Hypersomnia		Trembling/Shaking		Grandiosity/Mania		Use Alcohol
	Increased Appetite		Panic Attacks		Feel Detached/Unreal		History of Black Outs
	Decreased Appetite		Shortness of Breath		Nightmares		Feelings of Paranoia
	Isolate/Withdraw		Nausea/Diarrhea		Confusion		Delusions
	Feel Lonely		Fear of Losing Control		Flashbacks		Hallucinations
	Loss of Interest		Fear of Dying		Intrusive Memories		Physically Abusive to Others
	Recent Weight Gain		Tingling/Numbness		Lose Track Of Time		Verbally Abusive to Others
	Recent Weight Loss		Chills/Hot Flashes		Feel Detached from Others		Easily Angered/Frustrated
	Excessive Guilt		Fear of Crowds		Feel Numb		History of Incarceration
	Memory Impairment		Fear of Leaving Home		Self Harm (cut, burn, etc.)		History of Lying
	Suicidal Thoughts/Plan		Restless/On Edge		Have Abused Animals		Legal Issues (current or past)
	Homicidal Thoughts/Plan		Phobias (Heights, Animals)		Lack Empathy		History of Stealing
	Trauma History		Fear of Losing My Mind		Often Blame Others		Recent Medical Diagnosis
	Sexual Abuse History		Physical/Emotional Abuse		Feel Unsafe at Home		Recent Loss/Grief

Thinking about the **<u>past 2 weeks</u>**, rate severity of symptoms (**0= no symptoms, 10 = most severe ever**)

__ Angry __Depressed __Anxious/Stressed __Use of Drugs/Alcohol ___Suicidal Thoughts __Other

	Client	Birth Mother	Birth Mother's Family	Birth Father	Birth Father's Family	Siblings (who?)	Other Relative (who?)
ADD/ADHD							
Alcohol /Drug Abuse							
Anxiety/Panic Attacks							
Bipolar							
Depression							
Trauma/PTSD							
Other							

Substance Use/Gambling/Addiction History:

Substance	Specify Drugs Used	Date Last Used	Age of First Use	Frequency
Alcohol				
Amphetamines				
Benzodiazepines				
Opiates				
Marijuana				
Prescription Drugs				
Other:				
Other:				
Internet Addiction				
Sex Addiction				
Video Games				

Lost a job, become disorderly, fought, or got into trouble while using substances? Yes No

Considered yourself to have an addiction or need treatment? Yes No

Lost friends or relationships due to an addiction? Yes No

Attended AA, NA or other self-help groups? Yes No

Prior DUI (Driving Under the Influence) Yes No

Tried to quit using alcohol, drugs, internet or video games? Yes No

Borrowed money to gamble or cover lost money? Yes No

Thought you might have a gambling problem or told you might? Yes No

Hid your use of addiction(s) from others? Yes No

Do you own a firearm/weapon AND/OR is one in your home? If yes, what _______ Yes No

Are you involved in any legal issues at this time? Yes No

Medical Information:

Primary Care Physician: ______________________________ Last Physical _____________ Tel # _________________

List any medical conditions or recent illness: ____

Do you exercise? Yes No How much/week? __________ Do you smoke? Yes No How much/day? ________

Do you drink coffee or other caffeinated drinks daily? If yes, how much each day? ____________________________

List any/all allergies: ____

Marital/Family/Social History:

Who lives with you? Partner/Spouse Children Parent(s) Relative(s) Roommate(s) Other(s)

Marital Status: (circle) Single Married Separated Divorced Widowed In a Relationship

Marriages: ________ Date of marriage: ___________ Date of separation/divorce: ___________

Do you have any marital/relationship concerns? ____

Do you feel safe at home? Yes No If no, explain: ____

Religion: (if applicable) _______________ Community/Social/Group involvement: ___________________________

Children:

Name	Age	Live with you √	Biological Child √	Adopted √	Step Child √	Have custody? √

Deceased Children: Yes No Please explain: ____

Pregnancies _______ # Incomplete Pregnancies __________

Is DCF (Dept. of Children and Families) involved? Yes No Explain: ___________________________

DCF: Office: ____________________ Case Worker: ______________________________________

Education History: √ Highest Level of Education Completed.

__ Some High School __ High School __GED/Other __Some College __College __Post-Grad

If in school now, where? __________________________ Major: ________________________

Are current psychiatric or medical issues interfering with your ability to attend school? Yes No

Vocational History:

Are you currently employed: Yes No Where: ________________ How long have you been there? _______

Current position? ________________ # hours/week: ____ Do you enjoy this job? Never ___ Occ. __ Usually ___

Describe your relationship with your current supervisor/boss: Difficult: __ Manageable __ Enjoyable: __

If unemployed, for how long: _____ Reason for unemployment: _______________________________________

Are current psychiatric or medical issues interfering with your ability to work? Yes No

Do you receive Social Security Disability Income (SSDI), Unemployment or Workman's Comp? Yes No

Have you ever served in the military? Yes No When: ________ Branch: _________ Discharge Status: _______

Current Supports: (circle): Family Friends Co-workers Religion Community/Group Pets Other ________

Current Stressors: (circle) Primary Supports (family, relational) **Social Access to Healthcare**

Financial Occupational Educational Housing Legal Physical Issues

Psycho-Social/Environmental (discord with non-family, war) **Other** _____________

Hobbies/Interests: ____

Additional information: ____

Thank you for taking the time to complete this important assessment. 6.13.15