**Lisa Alber, LICSW Tel 978-866-1435**

**ADULT SELF-ASSESSMENT**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_

Gender: Cis-Female Cis-Male Transgender Non-binary Other: \_\_\_\_\_\_\_\_\_\_\_

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**:

Thinking of how you’d like to feel at the end of therapy, what are your expectations and goals of therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place a ![C:\Users\Lisa Alber\AppData\Local\Microsoft\Windows\INetCache\IE\IVS5LZC2\MC900072629[1].gif]() next to any current symptom.**

 **![C:\Users\Lisa Alber\AppData\Local\Microsoft\Windows\INetCache\IE\IVS5LZC2\MC900072629[1].gif]() ![C:\Users\Lisa Alber\AppData\Local\Microsoft\Windows\INetCache\IE\IVS5LZC2\MC900072629[1].gif]() ![C:\Users\Lisa Alber\AppData\Local\Microsoft\Windows\INetCache\IE\IVS5LZC2\MC900072629[1].gif]() ![C:\Users\Lisa Alber\AppData\Local\Microsoft\Windows\INetCache\IE\IVS5LZC2\MC900072629[1].gif]()**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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 |  | Preoccupation with Appearance |
|  | Hypersomnia  |  | Trembling/Shaking |  | Grandiosity/Mania |  | Use Alcohol or Use Drugs |
|  | 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 |
|  | Memory Impairment |  | Fear of Crowds |  | Feel Numb |  | History of Incarceration |
|  | Excessive Guilt |  | Fear of Leaving Home |  | Self Harm (cut, burn, etc) |  | History of Lying |
|  | Suicidal Thoughts |  | Fear of Animals |  | History of Trauma |  | Legal Issues (current or past) |
|  | Have Suicidal Plan |  | Fear of Heights |  | History of Sexual Abuse |  | History of Stealing |
|  | Homicidal Thoughts |  | Fear of Losing My Mind |  | Physical/Emotional Abuse |  | Recent Medical Diagnosis |
|  | Have Homicidal Plan |  | Physical Pain |  | Feel Unsafe at Home |  | Loss/Grief |

Over the **PAST 2 WEEKS**, rate severity of symptoms (**0= no symptoms, 10 = most severe ever**)

 \_\_\_Angry \_\_\_Depressed \_\_\_Mood Swings \_\_\_Use of Drugs/Alcohol

 \_\_\_Anxious \_\_\_Racing Thoughts \_\_\_Suicidal Thoughts \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Health Is  | Client | BirthMother | Birth Mother’sFamily | Birth Father | Birth Father’sFamily | Siblings(who?) | OtherRelative (who?) |
| ADD/ADHD |  |  |  |  |  |  |  |
| Alcohol /Drug Abuse |  |  |  |  |  |  |  |
| Anxiety/Panic Attacks |  |  |  |  |  |  |  |
| Bipolar |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Trauma/PTSD |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |

**Addiction History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **Specify Drug Used** | **Date Last Used** | **Age of First Use** | **Frequency** | **Typical Amount** **Consumed** |
| Alcohol |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Benzodiazepines |  |  |  |  |  |
| Opiates |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Prescription Drugs |  |  |  |  |  |
| Internet Addiction |  |  |  |  |  |
| Sex/Porn Addiction |  |  |  |  |  |
| Video Games |  |  |  |  |  |
| Gambling |  |  |  |  |  |
| Other |  |  |  |  |  |

Believe you have an addiction or need treatment? For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Lost a relationship or job, or got into other trouble due to addiction? Yes No

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

 Prior DUI (Driving Under the Influence)? When? \_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

 Tried to stop your addiction? Yes No

Hid your addiction(s) from others AND/OR others believe you have an addiction? Yes No

 Own a firearm/weapon AND/OR is one in your home? If yes, what \_\_\_\_\_\_\_ Yes No

 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**:

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relational difficulties with family/friends/others? (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Religious Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social activities/organizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Have you ever served in the military? Yes No When: \_\_\_\_\_\_\_\_ Branch: \_\_\_\_\_\_\_\_\_ Discharge Status: \_\_\_\_\_\_\_

**Current Supports: (circle): Family Friends Co-workers Religion Social Services Pets Other \_\_\_\_\_\_\_\_\_\_\_**

**Current Stressors: (circle)**  **Family-Relational** **Social** **Access to Healthcare** **Financial Occupational**

**Educational** **Housing Legal** **Health Issues Other**

**Hobbies/Interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Thank you for taking the time to complete this important assessment. 11/2023***