Adult Assessment

Demographic Information

Date: _________
Patient Name: ___________________________________
Patient Date of Birth: ______________
Home Address: ____
____
Phone number: ________________________________
Email: _____________________________________

Referred by: ____

Insurance/Billing Information

Insurance Company Name: ______________________________________
Policy ID number: _____________________________
Group number: ________________________

State the reason for today's appointment: __________________________________
____
____
How long has this been an issue? _________________
List the ways you have attempted to alleviate the issue so far:
____

Social History

Please name the people who reside in your home:

Name	Relationship	Age
______________________________	___________________	______
______________________________	___________________	______
______________________________	___________________	______
______________________________	___________________	______
______________________________	___________________	______

Who raised you? ___________________________________
Number of siblings? __________
How would you describe your relationship with your family of origin?
____
Did you suffer abuse as a child? Yes No
If so, what kind? Physical Sexual Neglect Please describe:
____

Has anyone in your family been diagnosed with a mental health issue in the past? Please list the family member and the diagnosis below:
____
____

What are the three biggest stressors in your life?

1. ____
2. ____
3. ____

Educational/Employment History

What is your highest level of education? ____________________

Are you currently working? Yes No

What is your occupation? ____

Marital and Legal History

Describe your marital status:
___single ___married ___engaged ___separated ___divorced ___widowed

Are you in a committed relationship at this time: Yes No
If yes, how long? _____________ Are you happy in your relationship? Yes No

Have you ever been arrested? Yes No
Describe: ____
Have you ever served time for a criminal conviction? Yes No
Describe: ____
Have you ever been involved in legal proceedings for any reason other than an arrest?
Yes No Please Describe: _______________________________________

Medical/Psychiatric History

Do you have a current or previous health issue that affects you daily?

Yes No

If yes, please provide details: ____

Current medications and dosage (include vitamins and supplements):

____
____
____
____

List previous psychiatric/behavioral health providers (inpatient and outpatient):

Provider name/Treatment facility	Diagnosis	Dates of service
______________________________	___________	___________
______________________________	___________	___________

Have you ever attempted suicide? Yes No
If yes, please describe: ____
____

Are you currently having suicidal thoughts? Yes No
If yes, please describe the thoughts: ____
____

Symptom Review

My mood is usually (circle all that apply):

Happy Sad Tense Unstable Angry

Current Symptoms (circle all that apply):

Sleep disturbance	Anxiety/Worry	Sadness	Phobia
Appetite changes	Change in sex drive	Social isolation	Hopelessness
Poor concentration	Poor motivation	Trouble making decisions	Low self esteem
Fatigue/Lack of energy	Fidgety	Loss of interest in preferred activities	Visual Hallucinations
Auditory Hallucinations	Emotional eating	Anger/ Irritability	Poor body image

List symptoms not listed above:
____
____

Substance Abuse History

Have you ever been treated for a substance abuse issue? Yes No

If yes, please describe: ____