More MH Counseling

ADULT COMPREHENSIVE ASSESSMENT

Name: _____ **Date:** _____
Age - DOB: _____ **Gender:** Male Female
Phone: _____ **Email:** _____
Emergency Contact: _____ **Phone:** _____

Health Insurance Information

Insurance: _____ Subscriber ID#: _____ Co-pay: _____

Personal

Primary Care Physician Name & Phone: _____

Current or hx of psychiatric medication? (what kind, what for, dose, frequency, duration, compliance): _____

Date last taken: _____
Name psychiatric prescriber: _____

Mental Health History

Mental Health Diagnosis Hx: _____

Outpatient Treatment Hx: _____

Psychiatric hospitalization Hx: _____

Self-Injury Hx: _____
Suicide Attempt Hx: (stressors) _____

Family hx of suicide attempts: _____
Violence Hx: (child, adolescence, adults) _____
Family Mental Health Hx: _____

Developmental History/Special Ed: _____

Trauma History: (physical, emotional, sexual abuse)

Recent life changes or stressful events?

Hours of sleep: (nightmares/flashbacks)
Hours of exercise: Appetite disturbances:

Substance Abuse Hx: (How many, how often, last use - onset)

Alcohol:
Heroin:
Cocaine:
Other:
Detox Hx:

Family Hx of Substance Abuse:

Professional/Educational

Occupational Status/Schedule (Full-time, part-time, unemployed, school):

Social and Family Relationships/Support

Family Status

Relationship Status: Single Relationship Engaged Married Separated Divorced
Living in your current household:
Describe family, siblings, birthplace:

Children?
Domestic Violence Hx:

Legal Status

Current & Hx Incarceration: (parole, probation, jail/state time/sexual offense?)

Clinical Impression 1: _____
Clinical Impression 2: _____
Additional Information:

Clinician Signature: _____ **Date:** _____