ADULT COMPREHENSIVE ASSESSMENT

Date: ___________________ Please Circle: Self-Pay or Insurance

Client information:
Name: ____________________________________
Age - Date of Birth: _________________________
Social Security #: ___________________________
Driver's License #: __________________________
Gender: Male Female

Contact:
Home Address: ____
Preferred Phone: ____
Email: ____
Preferred method of communication: Home Cell Email
Special Preferences? (Leaving messages, text, etc.) ________________________
____

Emergency Contact:
Name: ____
Phone: ____

Circle Preferred Form of Treatment:
Individual Individual In-Home Individual Office Group Counseling

Email support Phone support Email/Phone support

Health Insurance Information

Insurance Company's Name: ____
Name of Primary Insured: ______________________ Date of Birth: ___________________
Relationship to primary insured: ____________________________________
Subscriber ID#: ________________________Group #: __________ Co-Pay:__________

What are your reasons for seeking counseling services at this time? ________________
____
____

Referral Source: ____

Do you have any physical disabilities, limitation, or health problems that you aware of?

Transportation Issues: (Availability, accessibility)

Personal

Primary Care Physician Name & Phone:
Primary Care Physician Address:
Hx primary care physician prescribing psych meds?

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

Date last taken:
Name psychiatric prescriber:
Address psychiatric prescriber:

Mental Health History

Mental Health Diagnosis Hx:

Outpatient Treatment Hx: (Where, when, for what, compliance hx, diagnosis hx)

Successful hx of MH tx?

Unsuccesful hx of MH tx?

Current goals of therapy

Psychiatric hospitalization Hx:

Suicide Attempt Hx: (stressors)

Self-Injury Hx:
Family hx of suicide attempts:

Name of previous mental health provider & Dates of service:

Violence Hx: (child, adolescence, adults)

Family Hx of Mental Health Issues:

Developmental History: (Mental or physical problems)

Trauma History: (physical, emotional, sexual abuse)

Recent life changes or stressful events?

Average hours of sleep: (nightmares/flashbacks)
Average hours of exercise:
Appetite disturbances:

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

Alcohol:
Heroin:
Cocaine:
Other:

Detox Hx:

Current Disruption in Functioning:

Family Hx of Substance Abuse:

Are you seeking to make any changes related to substance abuse?

Professional

Highest Degree of Education:
Special education:
Developmental Disabilities:
Current Occupational Status (Full-time, part-time, unemployed, school):
Work Schedule:

Level of Satisfaction:

Strengths to employment: (driver's license, problem solving skills, motivation, list job skills, work history, communication skills)

Barriers to employment: (interfering psychiatric symptoms, physical limitations, motivation, transportation, communication skills)

Social Relationships/Support

Recreational activities or social interests: (structured, self-initiated, independent vs group, level of participation, substance abuse)

Supportive social supports: (Partner, Family, friends, sports, religious organizations)

Issues/Disruption in functioning:

Goals:

Family Status

Relationship Status: Single Relationship Engaged Married Separated Divorced

Living in your current household:

Rate satisfaction with current housing:

Relationship status?

How would you rate this relationship?

Briefly describe family, siblings, birthplace:

Do you have children? (Age. gender, educational, relationship, custody, child-support

Household physical/mental issues that influence mental health?)

Domestic Violence Hx:

Issues/Goals:

Legal Status

Incarceration Hx: (parole, probation, jail/state time)

Current status: (parole, probation, warrants, court dates, immigration)

Have you ever been convicted of a sexual offense? ______________________________
Goals/Issues: ____

Circle if it pertains to your reason or seeking mental health counseling at this time:

Memory	Disruptive Behavior	Drug Dependence	Unhappiness	Social Isolation
Shyness	Financial Problems	Self-Injury	Education	Legal Matters
Drug Use	Sleep Disturbance	Insomnia	Indecisive	Grief
Anger	Troublesome Thoughts	Inferiority	Empowerment	Loneliness
Stress	Problems with Anger	Health Problems	Nightmares	Parenting
Worry	Problems with Authority	Weight Control	Chronic Pain	Divorce/Separate
Attitude	Fatigue/Tiredness	Suspiciousness	Loneliness	PTSD
Fears	Sexual Problems	Low Self-Esteem	Education	Self-Control
Guilt	Poor Concentration	Mood Swings	Body Image	Social Isolation
Work	Housing Problems	Reproductive Prob	Relationship	Assertiveness
Family	Sadness/Depression	Suicidal Thoughts	Life Transitions	LGBT
Addiction	Impulsiveness	Family Relations	Incarceration	Bullying

Symptoms

Behavior

____ Acting strangely.
____ Attempting weight loss.
____ Seeking attention.
____ Arguing with others.
____ Dreading work.
____ Rejecting affection.
____ Not offering affection.
____ Not listening to others.
____ Not staying on track.
____ Difficulty waiting turn.
____ Checking/counting (ritual).
____ Exercising excessively
____ Fidgeting a lot.
____ Hoarding objects.
____ Initiating fights.
____ Losing things.
____ Showing inflexibility.
____ Being perfectionist.
____ Taking risks.
____ Startling easily.
Other: ___________________

Fears

____ Fearing abandonment.
____ Fearing crowds.
____ Fearing dying.
____ Fearing embarrassment.
____ Fearing gaining weight.
_____Fearing losing loved ones.

Feelings

____ Feeling agitated.
____ Feeling angry.
____ Feeling anxious.
____ Feeling self-conscious.
____ Feeling cocky.
____ Feeling depressed.
_____Feeling indecisive.
____ Feeling confused.
____ Feeling hopeless/helpless.
____ Lack of self-worth.
____ Feeling moody.
____ Feeling unstable.
Other: ___________________

Interpersonal

Physical Symptoms

____ Having poor social supports.
____ Feeling easily influenced.
____ Lacking friends.

Thoughts
____ Forgetting things.
____ Having delusions.
____ Having erratic thoughts.
____ Having intrusive thoughts.
____ Having paranoia.
____ Having rapid thoughts.
____ Hearing voices not there.
____ Lacking focus.
____ Lacking motivation.
____ Lacking organization.
____ Obsessing over symmetry
____ Seeing things not there.
____ Thinking of death.
____ Worrying about health.
Other:______________

____ Feeling chills.
____ Feeling muscle tension.
____ Feeling nauseated.
____ Feeling restless.
____ Sleepy in daytime.
____ Feeling too energetic.
____ Feeling too tired.
____ Gaining appetite.
____ Gaining weight.
____ Needing little sleep.
____ Sleeping too much.
____ Sleeping too little.
____ Sweating.
____ Rapid breathing.
____ Panic attacks.

Clinical Impression 1: ____
Clinical Impression 2: ____
Clinical Impression 3: ____
Clinical Impression 4: ____

Additional Information: ____
____
____

Clinician Signature: ____
Date: ___________________________________