authenticlife counseling
4485 Tench Road, Suite 1220
Suwanee, GA 30024
770-378-6835

Assessment

Medical History

Please describe any medical problems, significant physical symptoms or illnesses:

Medication Name	Dose/Frequency	Purpose	Prescribing Physician

Substance Name	Age of 1st Use	Age of Heaviest Use	Frequency/Amount	Route	
Alcohol					
Cannabis					
Opioids					
Cocaine					
Stimulants					

PRIOR PROVIDERS	DATES OF TREATMENT	DIAGNOSIS	SERVICES RECEIVED	RATE EXPERIENCE 1(Terrible)5(Excellent)

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Social Support, Relationships and Self-Care

Are you currently in a relationship? ☐Yes ☐No For how long? _____

Marital Status:
☐Married ☐Single ☐Engaged ☐Life Partner ☐Co-Habitation ☐Divorced ☐Separated ☐Widowed
Number of Previous Marriages: 0 Length of Time with current partner:

On a scale of 1-10 (1 being miserable and 10 representing excellent) how would you rate your current relationship? _____

Sexual Orientation:
☐Heterosexual ☐Homosexual ☐ Bisexual ☐ Transgender ☐ Questioning
Gender Expression:

Household Composition at time of Assessment		
Name	**Relationship**	**Age**

Do you consider yourself a spiritual person? ☐Yes ☐ No

If so how do you practice or engage in your spiritual life?

_____

Briefly describe your diet and exercise patterns: _____

_____

Do you feel as though you have a supportive network of friends? ☐Yes ☐No

What coping mechanisms have you used in the past which you felt were helpful?

_____

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What would you say you do to care for yourself on a regular basis? Include exercise, eating well, or hobbies _____

Education and Career

High School / GED ☐ College Degree ☐ Graduate Degree (or higher) ☐

Employment Satisfaction 1 2 3 4 5 6 7
POOR Excellent

What type of work do you do? _____

What would you describe as your strengths? _____
_____

Family:

Family of Origin (relationships/problems/issues). Describe family functioning and dynamics. Describe your relationship with biological parents and/or guardians, and siblings.

RISK AND TRAUMA ASSESSMENT (INCLUDE ABUSE/NEGLECT) *Check all that apply*					
Suicidality	☐None	☐Ideation	☐Plan	☐Intent w/o means	☐Intent w/means
Details:					
Homicidality	☐None	☐Ideation	☐Plan	☐Intent w/o means	☐Intent w/means
Details:					
Neglect	☐None	☐Emotional	☐Nutritional	☐Educational	☐Medical

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Details:					
Abuse	☐None	☐Physical	☐Sexual	☐Verbal/Emotional	☐Family Violence
Details:					
Trauma	☐None	☐Separation from family ☐Directly Experienced	☐Violence / Injury ☐Witnessed	☐Death ☐Learned it Happened to Someone Close	☐Other ☐Repeated Exposure (Vicariously)

Provide Details of Trauma Experienced or Witnessed below. *Include: Intrusive Symptoms, Avoidance Behaviors, Negative Alterations in Cognition and Mood.*

Please describe your presenting problem:

What are your goals for therapy?