4485 Tench Road, Suite 1220-A
Suwanee, GA 30024
678-618-0800

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					
Cocaine					
Stimulants *(Crystal, speed, amphetamines)*					

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

4485 Tench Road, Suite 1220-A
Suwanee, GA 30024
678-618-0800

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

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? _____

Marital Status:		
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

4485 Tench Road, Suite 1220-A
Suwanee, GA 30024
678-618-0800

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

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.

Neglect	☐None	☐Emotional	☐Nutritional	☐Educational	☐Medical
Details:					
Abuse	☐None	☐Physical	☐Sexual	☐Verbal/Emotional	☐Family Violence
Details:					
Trauma	☐None	☐Separation from family	☐Violence / Injury	☐Death	☐Other

4485 Tench Road, Suite 1220-A
Suwanee, GA 30024
678-618-0800

	☐Directly Experienced	☐Witnessed	☐Learned it Happened to Someone Close	☐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?

_____
_____
_____
_____