Assessment

Medical History

Please describe any medical or mental health diagnosis, symptoms or illnesses:

Medication Name	Dose/Frequency	Purpose	Prescribing Physician

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

Prior Providers	Dates Services Provided (approximate)	Diagnosis	Services Received	Rate Experience 1 (Terrible) 5 (Excellent)

Social Support, Relationships and Self-Care

Marital Status:
☐Married ☐Single ☐Engaged ☐Life Partner ☐Cohabitation ☐Divorced ☐Separated ☐Widowed
Length of Time With Current Partner:
Number of Previous Marriages: _____ **Length of Time Married:** _____ **Your Age At Time of Previous Marriage:** _____

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

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?

_____

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:	Date(s) of previous attempts**:**				
Homicidality	☐None	☐Ideation	☐Plan	☐Intent w/o means	☐Intent w/means
Details :					
Neglect	☐None	☐Emotional	☐Nutritional	☐Educational	☐Medical

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? If possible, make your goals specific and measurable.

Name: _____ Date:_____