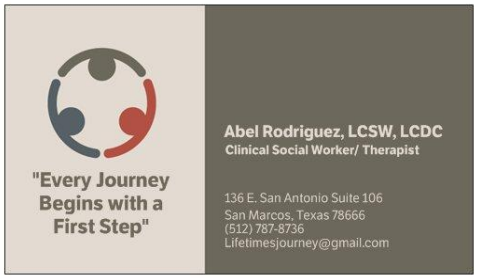


Adult Assessment Profile

Please complete the following information to the best of your ability and recollection.

Personal and Family history:

Name_____ Date_____
Address_____
Phone Number_____
Date of Birth_____ Driver License number_____ State _____
Present Job_____ Employer_____
Length of time at job_____ Education Level_____
Religion_____ Military service history_____
Approximate family income_____

Marital History:

Marital Status: ___Single ___Married ___Divorced___Partner ___Widowed

Spouse's Name	Marriage Dates From/To	Names/ages of children
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupation of spouse_____
Please list everyone else (other than your children) who lives in your home and state the relationship to you:

_____

_____

Your parent's names	Age (Deceased?)	Married or Divorced

_____

_____

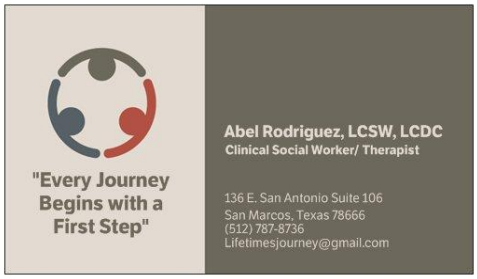
Please list your brothers and sisters by first name and give their age. Place yourself in the list.

_____

_____

_____

_____



Physical and Health Information

Physician: _____ Date of last physical Exam:_____
List significant illnesses, chronic medical conditions, or injuries with approximate dates:

_____

_____

_____

Have you ever been unconscious from a head injury? _____ If so, when?_____

Please check any item below that you have experienced:

Childhood		Adulthood
_____	Neglect	_____
_____	Physical Abuse	_____
_____	Verbal Abuse	_____
_____	Sexual Abuse	_____
_____	Injury due to Violence	_____
_____	Other Trauma	_____

Have you gained or lost any weight in the last year?_____
Do you have any concerns about your weight?_____
Has anyone in your biological family ever had a nervous breakdown, a mental illness, been depressed, had anxiety problems, attempted or committed suicide? If so, please state the relationship of the person to you and describe the problem he/she had:

_____

_____

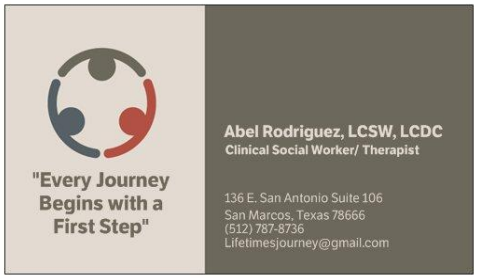
_____

Have you ever had previous counseling? If so, with whom (please give approximate dates of service):

_____

_____

_____



Social and Recreational Information

How do you spend your leisure time?_____
Please list other hobbies or interest_____
Do you have a close friend or friends? _____ **How often do you visit, entertain, or go out with people?**_____ **Do you exercise?** _____
Do you play sports? _____
Is there any reason you cannot exercise?

_____
_____

Legal Information

Have you ever been the victim or a crime? Circumstances

_____
_____
_____

Have you ever been arrested? Circumstances

_____
_____
_____

Are you currently involved in any litigation?

_____
_____
_____

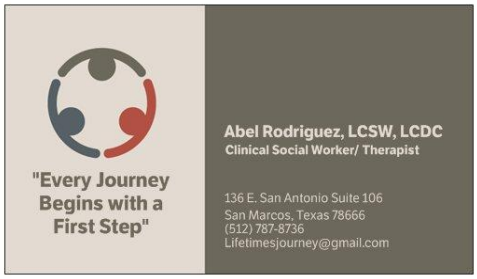
Presenting Problem

Please state the reason you are seeking services:

_____
_____
_____

What have you done to try and deal with this situation?

_____
_____
_____



How would you rate the severity of the problem?
____Mildly upsetting____Moderately Severe_____ Severe _____ Very Severe

What else would you like your therapist to know?

_____

_____

Please check any symptoms you are having and write down how many times a week do you feel that way (Example: X 3 xs)

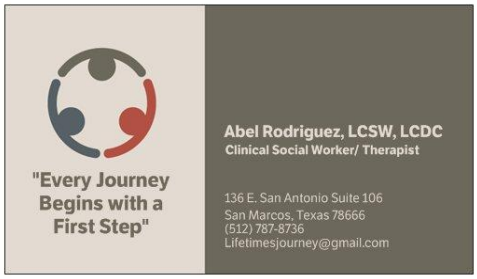
_____Tiredness
_____Sleep difficulties
_____Sleep too much
_____ Irritability
_____ Worry
_____ Crying
_____ Confusion
_____Lonely
_____Withdrawal
_____Loss of appetite
_____Overeating
_____ Anxiety
_____Panic attacks
_____Thoughts of suicide
_____Suicide attempt
_____Too passive
_____Too aggressive
_____Conflicts with others
_____Excessive anger
_____Excessive sadness
_____ Decreased sexual desire
_____Trouble concentrating
_____Loss of interest in activities
_____Thoughts of Better off dead
_____Other_____

When Did These Symptoms begin?_____

How difficult have these symptoms made it for you to do your work, take care of things at home, or get along with other people? Circle one

Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult

Please check all areas of your life affected by these symptoms:
_____Work performance
_____ Work relationships
_____ Daily Activities
_____Social activities
_____Family relationships
_____Marriage
_____ School/education
_____Other



Please indicate any major changes you have experienced in the past year:

_____Marriage
_____Re-marriage
_____ Separation
_____ Divorce
_____ Moved
_____ Illness, injury to self
_____ Illness, injury to other
_____Financial reversal
_____ Job change Loss of job
_____ Death of loved one
_____ Other

Confidentiality No one will reveal information concerning your counseling to anyone outside this office except as follows:

1) You consent in writing;
2) Life or safety is seriously threatened;
3) Disclosure is required by law;
4) You file a benefit claim and the claims pay or requires information.

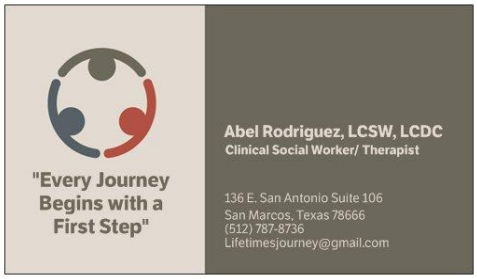
In addition, your counselor may consult with professional colleagues as needed for coordination of services, quality assurance, or payment.

I understand and accept these conditions

_____ _____

(Signature) **(Date)**

Thank you for providing this information. Your therapist will be happy to answer questions and address your concerns.



Medication Lists & Medical Allergies

Name_____ Date_____
Number of Medications: _____
List Allergies to Medications:

_____
_____

Medications currently taking:

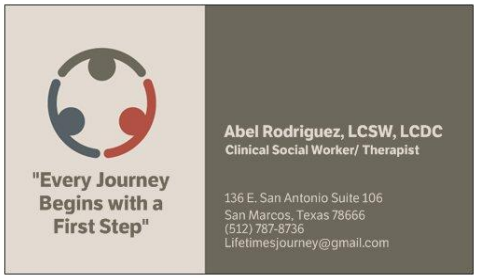
Medication/Start Date M.D. Name Dosage/Frequency

_____
_____
_____
_____
_____
_____
_____
_____

Substance	Amount	How Often	Used Began	Using	Last Used
Alcohol	_____	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____	_____
Heroin	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____
LSD	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____
Meth	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____
Opiates	_____	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Has anyone in your family had a drug or alcohol problem?

_____
_____



Please check all that apply:

___Mother
___ Father
_____ Grandfather
_____ Grandmother
_____ Sister
_____ Brother
_____ Uncle
_____Aunt
_____ Child
_____ Spouse

_____ _____

(Signature) **(Date)**