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**COUNSELING ASSESSMENT
REFERRAL AND BACKGROUND INFORMATION
(Adult Form)**

Today's Date:

Full Name: _____

Date of Birth: _____

Age: _____

Home address (es): _____

Phone Number: _____

Email Address: _____

Insurance and ID number _____

Emergency Contact name:

Home address: _____

Telephone Number: _____

Email Address: _____

Emergency Contact #2: _____

Home Address: _____

Telephone Number: _____

Email Address: _____

Names, ages, and birth dates of children and/or other household members :

Current Primary Care Physician or Practice:

Date of last physical: _____

Please explain any current familial stressors:

What types of activities do you most enjoy, and do you participate in any structured or formal activities?

What do you consider to be among your greatest strengths?

1. Briefly describe the main question, concern, and/or problem for which you are seeking evaluation at this time:

2. When did you first have this question, concern, or problem?

3. Have you ever sought assistance for this question, concern, or problem from other professionals? If so, please indicate from whom.

4. What is your current thinking regarding the most likely influences or causes of the concern or problem in question?

5. Whose idea was it to have this evaluation?

6. What are your treatment goals?

- A). _____
- B). _____
- C). _____

7. How do you generally function academically/ vocationally? Please describe strengths and weaknesses.

8. Please describe any significant health problems you have had in the past.

9. Do you have any health problems at present?

10. Do you take any prescribed medications, herbs, or homeopathic treatments? Please list dosages if known.

11. Describe your sleep habits/ bedtime rituals. Are there any concerns?

12. Describe your eating habits. Are there any concerns?

13. Do you have any visual issues? Do you wear corrective lenses?

14. Is there any family history of problems or differences with respect to learning or attention?

15. Is there any family history of clinically significant developmental disabilities, depression, anxiety, behavior and interpersonal problems, motor tics, and/or substance abuse?

Prior Evaluations, Testing, and Treatment:

1. Have you had any previous individual psychological, psychoeducational evaluations or "testing?" If so, please describe, and provide copies of reports if possible.

2. Have you ever been evaluated by or received treatment from a mental health professional?

Do you have a history of:

Abuse Physical Sexual Verbal Neglect Witnessing Domestic Violence/ Abuse? Yes No

depression anxiety behavior problems interpersonal problems motor or vocal tics
 substance abuse

Please Describe:

Experiencing the loss of death of a close loved one?

Yes No If yes, please list (who and date):

Experiencing any other traumatic events (i.e., medical, natural events, school/ community violence, bullying)? Yes No If yes, please list (what and date):

Hearing voices no one else hears or seeing things no one else sees? Yes No

History of Harm to Self/ Others:

Past Suicidal Thoughts/ Gestures: Denied Ideation Plan Intent Current Suicidal Thoughts/ Gestures: Denied Ideation Plan Intent

Aggression towards other: Yes No If yes, please describe: _____

Past Homicidal Thoughts/ Gestures: Denied Ideation Plan Intent

Current Homicidal Thoughts/ Gestures: Denied Ideation Plan Intent

Past history of self-harm: Yes No

Currently engaging in self-harm: Yes No

If yes, age of onset, duration, and was medical attention needed: _____

CURRENT CONCERNS:

Emotional:

Irritable or Depressed Mood Avoids certain items, places, situations, persons Tearfulness or Frequent Crying Spells Panic Attacks Loss of Interest in Activities Low Self-Esteem Sadness Loss of Energy Repetitive/ Obsessive Thoughts Confusion About Self Mood Swings Anxiety/ Worry/ Fears Easily Startled Temper Tantrums Flashbacks Loss of Energy Trouble Expressing Emotions Nightmares Trouble Calming Down Overreacts When Faced with a Problem Hides Feelings Other (list):

Physical:

- Difficulty/ Changes in Sleep Changes in Appetite or Eating Habits Headaches
Dizziness Change in weight Stomachaches Other (list):

Behavioral:

- Concentration/ Focus Problems Avoids Tasks that Are Difficult or Boring Loses Items
 Not Completing Tasks to Completion Trouble Remaining Seated Easily Distracted
 Daydreams/ Zones Out Always "On the Go" Restless or Fidgety Impulsive
 Hyper-focuses Makes Careless Mistakes Self-Hygiene Habits Strict Routines

- Repetitive Body Movements, Motor or Verbal Tics

- Verbal Aggression Physical Aggression Lying Stealing Cruelty to Animals
Defiance/ Noncompliance Tantrums Truancy (home or school) Sexual Behaviors
Blames Others Argues with Others Trouble Accepting Responsibility/ No Fire-setting
Substance Use Legal Problems

- Hair-picking Purging/ Restricting Food Calorie Counting Excessive Exercise Other
(list):

Social:

- Family Conflicts Negative Relationships Isolates Self / Withdraws from Others
 Difficulty with Communication/ Respect towards others Difficulty Making Friends
 Difficulty Keeping Friends Poor Eye Contact Difficulty Reading Social Cues
 Difficulty Respecting Others' Personal Space Difficulty with Sportsmanship
 Clingy/ Trouble Separating Difficulty with Attachment to Others Joining In Social
Media/ Online Interactions Bullies Others History of Being Bullied Overly Stimulated

History of speech therapy? Yes No If so, when/ where?

History of occupational therapy? Yes No
If so, when/ where?

Do you have any sensory difficulties? Yes No If so, please describe (loud sounds, textures, smells, crowds, lights, etc.):

MEDICAL HISTORY

How is your general health? History of: Physical Disabilities Asthma Head Injury Surgeries Stitches Broken Bones Burns Overnight Hospitalizations Frequent Ear Infections Seizures Vision Problems Loss of Consciousness Chronic Illness Severe Illness Hearing Difficulties Constipation/ GI Problems Feeding or Eating Issues Allergies (List): Previous medication trials? Yes No Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.

You may skip this section if you bring a printout of meds generated by your pharmacy at the time of the initial appointment

Current medication? Yes No

Please list any medication(s) and the dosage(s) your child is currently taking, including any over-the-counter medications (daily vitamins, hormones, herbal supplements, allergy medications and/or frequent dosages of acetaminophens/ ibuprofen):

ACADEMIC HISTORY Please list all schools attended

High School: _____

College: _____

Graduate School: _____

Current School: _____

Have you ever had an IEP (Individualized Education Plan)? Yes No

If so, starting in which grade? _____

Have you ever had a 504 Plan Yes No

If so, starting in which grade? _____

FAMILY HISTORY

Marital/ Couple Relationship: Positive Negative Variable N/A

Co-parenting Relationship: Positive Negative Variable N/A

Sibling Relationship(s): Positive Negative Variable N/A

Extended Family Relationships: Positive Negative Variable N/A

Children are : Biological Adopted Foster Other

Please describe relationships with significant family members/ and or significant others:

How do family members get along?

Biological Parents are: Married Divorced* Separated* Never Married

MENTAL HEALTH HISTORY Previous diagnosis(es)? Yes No

If yes, specify:

Previous history of therapy/ counseling? Yes No

If yes, specify name of therapist/agency, dates of treatment, type of therapy if you know it (CBT, DBT, etc.):

Previous history of psychological evaluation? Yes No If yes, specify date(s) and evaluator or agency. Please provide copies of any reports or evaluations if you have them.

Previous history of psychiatric hospitalizations? Yes No

If yes, specify hospital name, dates, and length of stay:

Previous psychiatric hospitalizations for family members? Yes No

If yes, please specify:

Any family members with history of mental health disorders? Yes No

If yes, specify:

Any family members with history of suicide? Yes No

If yes, specify:

SOCIAL INTERACTIONS/ FRIENDSHIPS/ RECREATION

Do you relate/ play well with others: Yes No

If no, describe:

You get along better with individuals who are (check all that apply):

Younger Same Age Older Same Sex Opposite Sex

What activities or hobbies does you enjoy?

CULTURAL BELIEFS AND PRACTICES

Do you/ your family identify with a specific cultural or ethnic group? Yes No If yes, specify:

Do you/ your family belong to a particular religion or spiritual group? Yes No

If yes, specify:

If you/ your family does not belong to a group, do you have any spiritual beliefs or life philosophies that is important to you? Yes No

If yes, specify:

Are there any other cultural/religious considerations/ needs that we should be aware of?

Yes No

If yes, specify:

Please share any other information that you believe may help my ability to provide effective care.
