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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:_____

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.

_____
_____
_____