DESERT STREAMS Christian Counseling

ADULT INITIAL ASSESSMENT

Date _____

Name _____ **Sex:** **M** **F** **SSN #:** _____

Address _____ **Date of Birth** _____ **Age** _____

City _____ **ST** _____ **Zip Code** _____ **Home Phone** _____

Employer _____ **Work Phone** _____

Email Address _____ **Cell Phone** _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact _____ **Relationship** _____ **Phone** _____

Your hope for counseling? _____

_____

_____

_____

Is there anyone you want involved in your counseling? (ex: spouse, pastor, teacher, etc.) _____

_____

EMPLOYMENT HISTORY

Current Employer _____ **Length of employment** _____

Position/Title _____ **Job satisfaction** _____

EDUCATIONAL HISTORY

Highest grade completed? _____ **Name of school** _____

Area of study _____ **Do/did you like school?** ☐ No ☐ Yes **Explain** _____

_____

Describe school performance _____

Have you ever been diagnosed with a learning disability? ☐ No ☐ Yes **Explain** _____

Have you ever been diagnosed with ADD/ADHD? ☐ No ☐ Yes

MILITARY HISTORY

Were you in the military? ☐ No ☐ Yes **Branch** _____ **Enlisted?** _____ **Drafted?** _____

Tour _____ **Dates Served** _____ **Combat** ☐ No ☐ Yes **Stationed** _____

Type of discharge _____

LEGAL SYSTEM INVOLVEMENT

Have you ever been involved with the legal system? ☐ No ☐ Yes **If yes, please explain** _____

_____

_____

MARITAL/RELATIONSHIP HISTORY

Current Spouse's / Partner's Name _____ **Age** _____ **Length of Relationship** _____

Were you previously married? ☐ No ☐ Yes **Was your spouse/partner?** ☐ No ☐ Yes

CHILDREN

Name	Age	Relationship	Lives with you?
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes

FAMILY HISTORY

Father's Name _____ **DOB** _____
Education _____ **Occupation** _____
Mother's Name _____ **DOB** _____
Education _____ **Occupation** _____
Marital status of parents: _____

Stepfather's Name _____ **DOB** _____
Education _____ **Occupation** _____
Stepmother's Name _____ **DOB** _____
Education _____ **Occupation** _____

Where were you born? _____ **Who raised you?** _____
Were you adopted? ☐ No ☐ Yes **If yes, at what age?** _____

BROTHERS & SISTERS (full, half or step)

Name	Age	Occupation	Marital Status

Have you or any member of your family experienced any of the following? (check all that apply)

ADDICTIONS

☐ **Alcohol: Who?**

_____

☐ **Drugs: Who?** _____
☐ **Food/Eating: Who?** _____
☐ **Gambling: Who?** _____
☐ **Sex/Pornography: Who?** _____
☐ **Relationship/Love: Who?** _____
☐ **Other** _____ **Who?** _____

EMOTIONAL PROBLEMS

☐ **Depression: Who?** _____

☐ **Anxiety: Who?** _____

☐ **Panic Attacks: Who?** _____

☐ **Manic/Depression: Who?** _____

☐ **Obsessions: Who?** _____

☐ **Suicide attempts: Who?** _____ **Completed: Who?** _____

☐ **Phobia/fears: Who?** _____

☐ **Anger/Explosive: Who?** _____

☐ **Other** _____ **Who?** _____

Have you or any member of your family been hospitalized for any of the above? ☐ No ☐ Yes

If yes, who? _____

ABUSE: (to self/family members)

☐ **Physical: Self/Family?** _____ **by whom?** _____

☐ **Emotional: Self/Family?** _____ **by whom?** _____

☐ **Sexual: Self/Family?** _____ **by whom?** _____

☐ **Spiritual: Self/Family?** _____ **by whom?** _____

Did you ever witness violence in your home or elsewhere while growing up? ☐ No ☐ Yes **If yes, explain** _____

_____

_____

PHYSICAL, PSYCHOLOGICAL AND SOCIAL HISTORY

Physician's Name _____ **Name of Practice** _____

Address _____ **Phone** _____

Date of last visit _____ **Reason** _____

List any current or past medical conditions _____

_____

_____

List any hospitalizations, psychiatry, or therapy _____

_____

_____

_____

List any surgeries and dates _____

_____

_____

List all current medications (dosage, frequency and purpose) _____

_____

_____

List any allergies _____

_____

List past use of medications for depression, anxiety, ADD/ADHD, sleep, weight control, smoke cessation, etc.? _____

_____

_____

Do you drink alcohol? ☐ No ☐ Yes **If yes, how much and how often?** _____

_____

Do you smoke cigarettes or chew tobacco? ☐ No ☐ Yes **If yes, how much and how often?** _____

_____

Do you consume caffeine? ☐ No ☐ Yes **If yes, how much and how often?** _____

_____

Do you vape or consume cannabis? ☐ No ☐ Yes **If yes, how much and how often?** _____

_____

Do you consume any other substances? ☐ No ☐ Yes **If yes, how much and how often?** _____

_____

CURRENT SYMPTOM CHECKLIST

Are you currently experiencing any of the following? (check all that apply)

___ Anxiety/Nervousness	___ Anger	___ Bad dreams/nightmares	___ Compulsive Behaviors
___ Crying often	___ Depression	___ Easily annoyed	___ Violent Thoughts
___ Mood Swings	___ Loneliness	___ Loss of Hope	___ Trouble Managing Money
___ Obsessive Thoughts	___ Problem in Relationships	___ Weight Loss or Gain	___ Racing Thoughts
___ Sexual problems	___ Panic Attacks	___ Trouble Concentrating	___ Trouble Sleeping
___ Irritable Bowel	___ Work Problems	___ Fatigue	___ School Problems
___ Headaches	___ Low Self Esteem	___ Social Withdrawal	___ Backaches
___ Seizures	___ Restlessness	Other: _____	

Describe any losses that you have experienced (i.e. health issues, death, divorce, pregnancy loss, retirement, moves, etc.)

_____

_____

_____

PREVIOUS COUNSELING

Have you ever had formal counseling? ☐ No ☐ Yes **How many times?** _____

With whom? _____

When? _____

Why? _____

Was it inpatient or outpatient? _____

Was it helpful? ☐ No ☐ Yes **Explain** _____

_____

_____

Describe the last major change in your life _____

_____

_____

HISTORY

Do you have people in your life that you consider close friends? ☐ No ☐ Yes

When going through a difficult experience in your life do you have someone to confide in? ☐ No ☐ Yes

What activities/hobbies do you enjoy participating in? _____

_____

Are you a member of any group or organization? ☐ No ☐ Yes **Explain** _____

_____

_____

List two strengths about yourself _____

_____

_____

List two things about yourself that you would like to change _____

_____

_____

SPIRITUAL HISTORY

Are you affiliated with a church? ☐ No ☐ Yes

If yes, which church? _____ **Pastor's name** _____

How involved are you in the congregation? _____

Attendance: ☐ Never ☐ Sometimes ☐ Regularly

ADDITIONAL INFORMATION

What else should your therapist know about you?

_____

_____

_____

_____

_____

_____