

OUTPATIENT INITIAL ASSESSMENT
ADULT PATIENT INFORMATION
PART I

Instructions: To assist us in understanding and helping you, please fill out this form as completely as possible. This information is confidential and only released with your permission.

Identification:

Patient's Name _____ Date _____

Form completed by (if other than Patient) _____

Gender ___ F ___ M Date of Birth _____ Age _____ Soc. Sec. # _____

Address _____

Street & Number _____ City _____ State _____ Zip Code _____

Phone # Home () _____ Work () _____ Cell () _____

When contacting you by telephone, may we leave a message on your answering machine?

Home No Yes Work No Yes

Reason(s) for Seeking Services:

- Alcohol/drugs
- Anxiety
- Depression
- Eating disorder
- Fear/phobias
- Life changes
- Grief/Loss
- Relationship problems
- Other mental health concerns (specify) _____

Referred by: _____

What do you hope to accomplish in therapy? _____

Signs/Symptoms: (check those that are problematic to you)

- Angry outbursts
- Anxious feelings
- Appetite change
- Concentration difficulties
- Crying spells
- Depressed mood
- Disorganized thoughts
- Energy level changes
- Excessive guilt
- Feel like hurting others
- Withdrawing
- Hallucinations
- Health worries
- Hopeless/helpless
- Impulsive behaviors
- Irritable
- Loneliness
- Money management
- Mood shifts
- Not enjoying things
- Panic attacks
- Gambling
- Recurring behaviors
- Recurring thoughts
- Recurring pain
- Self-harm
- Sexual problem
- Sleep problem
- Suicidal thoughts
- Worrying excessively
- Unable to experience forgiveness
- Unable to pray

Other (specify) _____

How do the symptoms you checked affect your daily functioning? _____

Personal Information:

What are your greatest strengths? _____

What are your greatest weaknesses? _____

Currently living with you:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Children living out of your home: (if applicable)

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Supportive Relationships:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Marital Status: (check all that apply)

- Never married
- Committed Partnership
Length of time _____
- Legally married
Length of time _____
- Separated
Length of time _____
- Divorce in process
Length of time _____
- Divorced
Length of time _____
- Widowed
Length of time _____
- Total number of marriages (if applicable) _____

Extended Family:

	Name	Age	Living?	Occupation	Quality of Relationship
Father	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Mother	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Stepfather	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Stepmother	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Sibling	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Sibling	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Sibling	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Sibling	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Which of the following best describes your family in which you grew up? (circle) _____ ber along the continuum below with 1 being the best, 10 the worst)

Warm & accepting			Average				Hostile & Fighting		
1	2	3	4	5	6	7	8	9	10

Trauma History:

Have you had a history of trauma or abuse? No Yes If yes, what type of abuse or trauma occurred?
___ Physical ___ Sexual ___ Emotional ___ Neglect Abuse was as: ___ Victim ___ Perpetrator

Social Relationships:

How do you usually get along with people?
___ Avoidant ___ Shy ___ Leader ___ Outgoing ___ Assertive ___ Follower ___ Irritable
Has there been a recent change in your attitude/relationships with others? No Yes If yes, circle the above word that describe that change.

Optional: What is your sexual orientation? ___ Heterosexual ___ Bisexual ___ Homosexual

Cultural/Ethnic Concerns: Do you have concerns related to cultural or ethnic issues? No Yes If yes, explain: _____

Spiritual/Religious History:

In your experience, how important are spiritual matters? _____
What is your present religious affiliation? _____
Do you have spiritual concerns that you would like to address in the therapy process? No Not sure Yes.
Describe _____

Legal History: (if applicable)

Are you currently involved with the legal system? No Yes If yes, explain _____

Have you been involved with the legal system in the past? No Yes If yes, explain _____

Do you currently have a probation or parole officer? No Yes If yes, name _____

Educational History: (check all that apply)

___ Currently in school No Yes ___ High School Grad/GED No Yes
___ Vocational Graduated No Yes Major _____
___ Graduate School Graduated No Yes Major _____
___ College Graduated No Yes Major _____

Did you experience any of the following problems in school? ___ Learning ___ Emotional ___ Discipline ___ Social

Do you currently experience any of the following learning barriers?
___ Learning disability ___ Vision impairment ___ Hearing impairment ___ Language

I learn best through: (check all that apply) ___ Discussion ___ Written materials ___ Videos ___ Tapes

What is your primary language? ___ English ___ Spanish ___ Sign ___ Other

Employment History: (circle those that apply)

List job history beginning with most recent job

Employer	Dates	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Status: Full-time Part-time Disabled Laid off Retired Student

Homemaker Other _____

Attendance problems Performance problems Work load Medical leave Employer concerns

Potential for lay off Dislike job Relationship problems with coworkers

Other _____

Financial Status: (circle) Stable Unstable Comments _____

Military History:

Military experience No Yes If yes, specify branch and dates of service.

Branch	Date Enlisted	Date Discharged
_____	_____	_____

Leisure/Recreational:

Hobbies/Interests

Recent change in frequency?

_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency

Personal Counseling/Treatment History:

Please provide past and present information.

	No	Yes	When	Purpose	Result
Counseling/Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Self-help Groups	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Family/Significant Other's Counseling/Treatment Information:

	No	Yes	Relationship	Reason	Response
Counseling/Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drug/Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Self-help Groups	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Substance Abuse History

Do you use alcohol or drugs? No Yes If yes, what is your current substance of preference? _____

Do you see your use as a problem? No Yes If yes, how motivated are you to make changes?
___ Unsure ___ Somewhat ___ Very

Is your current living situation and/or family helpful in supporting any changes? (please explain)

Have you received inpatient or outpatient treatment or educational programs for alcohol or drug use?

Where & With Whom	Type of Treatment	Dates	Was it Helpful
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever tried to cut down on your alcohol or drug use or quit using? No Yes If yes, please explain _____

Has alcohol/drug use interfered with family or interpersonal life? No Yes If yes, please explain _____

Have you experienced any of the following in relation to your alcohol or drug use?

- ___ Anxiety
- ___ Depression
- ___ Hallucinations
- ___ Inability to abstain
- ___ Other adverse reactions (Please explain) _____
- ___ Increased tolerance
- ___ Loss of control
- ___ Memory loss
- ___ Overdoses
- ___ Preoccupied with substance
- ___ Stomach problems
- ___ Tremors
- ___ Withdrawal symptoms

Signature: _____ Date: _____

Relationship to patient (if other than patient) _____

Thank You

Reviewed by Clinician: _____ Date: _____