

# Adult Assessment Form

## Client One:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Is it ok to leave a message? \_\_\_\_\_

Cell phone numbers: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

## Client Two:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Is it ok to leave a message? \_\_\_\_\_

Cell phone numbers: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Information supplied by (name and relationship to the client): \_\_\_\_\_

Presenting problem(s) or why you are seeking therapy (briefly):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What symptoms or changes have you seen in yourself or your relationship?

\_\_\_\_\_  
\_\_\_\_\_

When did you first notice these changes (approximately)? \_\_\_\_\_

\_\_\_\_\_

## Marital History/Current History

Client One:

Married To: \_\_\_\_\_

Separated From: \_\_\_\_\_

Divorced From: \_\_\_\_\_

Remarried To: \_\_\_\_\_

Client Two:

Married To: \_\_\_\_\_

Separated From: \_\_\_\_\_

Divorced From: \_\_\_\_\_

Remarried To: \_\_\_\_\_

## Family and Home Information

All persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Regarding the above persons:

A. Do any of them have physical or emotional problems?  No  Yes

If "yes," please explain: \_\_\_\_\_

\_\_\_\_\_

B. If "yes," have they received counseling or other forms of help?  No  Yes

If "yes," please explain: \_\_\_\_\_

\_\_\_\_\_

Is your house troubled by domestic violence (now or in the past)?  No  Yes

If "yes," please explain: \_\_\_\_\_

\_\_\_\_\_

Does any family member have an alcohol or drug problem (now or in the past)?

No  Yes

If "yes," please explain: \_\_\_\_\_

\_\_\_\_\_

Has anyone in your family ever experienced head injuries or serious illness?  No  Yes

If "yes" please explain: \_\_\_\_\_

\_\_\_\_\_

Name of primary physician and phone number: \_\_\_\_\_

\_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

\_\_\_\_\_

Is anyone currently experiencing any medical problems?  No  Yes If

"yes" please explain: \_\_\_\_\_

\_\_\_\_\_

Please describe other problems: \_\_\_\_\_

\_\_\_\_\_

---

What problem distresses you the most? \_\_\_\_\_

---

What do you think are your greatest strengths? \_\_\_\_\_

---

Please describe the changes you hope to see as a result of our work:

---

---

---

---

---

---

---

---

---

---

**Referral1 Information**

If you were referred by another professional (physician, clergy, therapist, etc.) please fill out the information below:

---

Name of referring professional

---

Address

---

City, State, ZIP Code

May we have your permission to notify the referring professional that you have participated in your first session of therapy and thank them for their referral?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If you wish us to continue receiving information from and/or providing information to the referring professional regarding your treatment, please complete an "Authorization to Release Information Form."