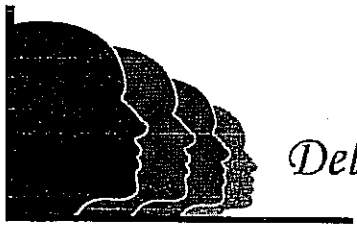

Delta Psychological & Neurobehavioral Services

ADULT PSYCHOSOCIAL

Name: _____ DOB: _____ DATE: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

What brings you to our Clinic? _____

_____

Are there family members or friends who you think will be supportive of your treatment?

_____

What would you like to accomplish here?

_____

MENTAL HEALTH ASSESSMENT:

Describe those thoughts, feelings, behaviors or situations causing difficulty for you: _____

_____

Do you have any concerns or problems in any of the following areas?

Appetite/eating _____

Sleeping _____

Sexual activity _____

Sexuality _____

Energy level _____

Physical or sexual abuse _____

Temper tantrums/Anger _____

Nervousness/excessive worry _____

Memory or recall difficulties _____

Repetitive behaviors _____

Persistent feelings of sadness/hopelessness _____

Thoughts of harming someone else, harming yourself, or being harmed by someone else _____

Other _____

Do you have any special concerns or problems getting along with your children, parents, coworkers, spouse, or significant other?

_____

What do you consider your strengths? _____

What do you consider your weaknesses? _____

Have you had any mental health treatment in the past? (Where, when and if successful) _____

_____

_____

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Therapist summary:

BACKGROUND: FAMILY OF ORIGIN

Briefly describe your biological parents, your relationship to them, and whether they are living: _____

_____

_____

Who raised you as a child? (biological mother, biological father, other?) _____

_____

List all siblings by name, age, sex: _____

_____

Briefly describe the kind of living situation you grew up in: _____

_____

What is your cultural/ethnic background? _____

Spiritual/religious orientation in your family of origin: _____

Have there been any of the following kinds of problems with any of your blood relatives?

Severe temper tantrums or mood problems _____

Mental illness: _____

Problems with alcohol or other drug abuse: _____

Physical or sexual abuse: _____

Criminal behavior: _____

Homicidal or suicidal behavior: _____

Any serious problems or unusual circumstances with your birth? _____

Any special problems or challenges you faced growing up as a child? _____

_____

The best part of your youth was _____

The worst part of your youth was _____

Therapist summary:

BACKGROUND: PERSONAL

How did you do in school? _____

Highest grade completed: _____

Any time in the military? _____

Are you currently employed? _____

Marital status: _____

List all children: (Names, ages, whether living with you) _____

_____

What is your current living situation? _____

What are your current spiritual/religious practices? _____

Do you have any money problems? _____

Do you have any legal problems? _____

Do you have an arrest history? _____

What do you do for recreation or as a hobby? _____

Therapist summary:

HEALTH/MEDICAL:

Check all that are problem areas:

Abdominal pain _____	Dizziness _____	Headaches _____	Sleep problems _____
Bed wetting _____	Ear infection _____	Hearing problems _____	Weight loss _____
Breathing problems _____	Tics or twitching _____	Eye/vision problems _____	Weight gain _____
Chest pain _____	Fainting spells _____	Nausea _____	Vomiting _____
Chronic pain _____	Fatigue _____	Nose bleeds _____	Hot flashes _____
Constipation/diarrhea _____	Frequent urination _____	Other bleeding _____	
Heat/cold sensitivity _____	Coughs _____	Allergies _____	Menstrual pain _____
Sweating _____	Sore throat _____	Prostrate _____	Other _____

Check all that have occurred at any time:

AIDS/HIV _____	Dental problems _____	Rheumatic fever _____	Anemia _____
Glaucoma _____	Seizure _____	Arthritis _____	Heart disease _____
Asthma _____	High blood pressure _____	Thyroid problems _____	Kidney disease _____
Cancer/tumor _____	Diabetes _____	Venereal disease _____	Blood transfusion _____
Loss of consciousness _____	Blows to the head/head injury _____	Stroke _____	
Abuse: physical/sexual/verbal _____	Pregnancy _____	Other _____	

List any operations or hospitalizations for medical problems: _____

_____

Are you currently taking any prescribed medication? (Add additional sheet if necessary)

Drug	Dose	Times daily	Physician	Condition

Over-the-counter medications taken regularly (include herbal preparations):

Drug	Frequency	Amount	Condition

Are you allergic to any medications? _____

Are you currently under the care of a physician for any active medical problems at this time? _____

Name of primary care physician: _____

Office location: _____

Date of last physical examination: _____

Therapist summary: Include relevant medication history.

SUBSTANCE USE ASSESSMENT:

Have any of your blood relatives have what you would call a significant drinking or drug use problem – one that did or should have led to treatment? _____

Do you now, or have you ever, had a problem with alcohol or drugs? _____

Has anyone else ever said you have/had a problem with alcohol or drugs? _____

Have you ever been in treatment for substance use? _____

Have you ever attended support groups for substance use? _____

Therapist summary: (include substance use history)

SUMMARY:

Is there anything else we should know about you? _____

_____

THERAPIST NOTE ON ORIENTATION: _____

_____

_____

Client signature/date

Interviewing clinician/date