

# The Center for the Advancement of Human Potential

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## INITIAL ADULT ASSESSMENT

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ Handedness: R L Mixed

Who referred you to our office \_\_\_\_\_

What is your major concern that led you to seek help? \_\_\_\_\_

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What other concerns do you have? \_\_\_\_\_

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Have you ever been assessed, had testing, or received counseling before? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, describe when, with whom, and what happened. \_\_\_\_\_

Do you currently have a psychiatrist? No \_\_\_\_\_ Yes \_\_\_\_\_ Name \_\_\_\_\_

Do you currently have a therapist? No \_\_\_\_\_ Yes \_\_\_\_\_ Name \_\_\_\_\_

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## PHYSICAL HEALTH

Primary Care Physician \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Would you like us to inform your doctor of your treatment received here? No \_\_\_\_\_ Yes \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent Gain or Loss? \_\_\_\_\_

For what conditions are you currently being treated, including those treated by doctors or providers other than your primary care doctor? \_\_\_\_\_

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**Please list all other current and previous treatments, medications, or therapies, indicating dates and results or effectiveness.** \_\_\_\_\_

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**Do you have any environmental allergies, food or medication sensitivities?** \_\_\_\_\_

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### **DEVELOPMENTAL HISTORY**

**Were there any problems/complications during pregnancy or delivery?** No \_\_\_ Yes \_\_\_ Unsure \_\_\_

**Were you adopted?** No \_\_\_ Yes \_\_\_ **If yes, at what age?** \_\_\_\_\_

**Did you have any developmental delays or problems in learning to crawl, walk, use fine motor skills or talk?** No \_\_\_ Yes \_\_\_ **Please describe:** \_\_\_\_\_

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**As a child did you experience any significant stressors, such as family crisis; conflict with parents, siblings or peers; serious illness; frequent moving; family drug or alcohol abuse?** \_\_\_\_\_

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**Please check any of the following that were a problem for you during your school years:**

\_\_\_ Reading difficulties including dyslexia (trouble learning to read), poor tracking while reading (losing place in line, missing words), and poor comprehension or recall.

\_\_\_ Math difficulties including poor arithmetic calculation, poor sequential processing (doing things in order), and poor math concepts.

\_\_\_ Writing difficulties including poor spelling, and inability to write neatly.

\_\_\_ Poor visual-spatial skills (drawing, copying figures)

\_\_\_ Poor grades

\_\_\_ Homework problems

\_\_\_ Behavior problems

\_\_\_ Peer problems

\_\_\_ Disliked/avoided school

\_\_\_ Other \_\_\_\_\_

Please describe: \_\_\_\_\_

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Highest educational level completed? \_\_\_\_\_

Current employment \_\_\_\_\_

Previous employment history: \_\_\_\_\_

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**BEHAVIORAL ISSUES**

**Please indicate if you have or have had difficulty in any of the following areas and explain below.**

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|-------------------------------------|--------------------------|-------------------------------------|
| _____ Inattention                   | _____ Distractibility    | _____ Anger tantrums                |
| _____ Impulsivity                   | _____ Depression         | _____ Compulsive behavior           |
| _____ Irritability                  | _____ Agitation          | _____ Muscle/ Verbal Tics           |
| _____ Anxiety                       | _____ Fears              | _____ Lack of remorse               |
| _____ Obsessive<br>thoughts/worries | _____ Phobias            | _____ Inability to read social cues |
| _____ Panic attacks                 | _____ Poor concentration | _____ Poor self-esteem              |
| _____ Daydreaming                   | _____ Poor insight       | _____ Poor peer relations           |
|                                     | _____ Stimulus seeking   | _____ Poor sibling relations        |
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**What conditions or triggers seem to worsen your condition?** \_\_\_\_\_

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**What helps to calm you?** \_\_\_\_\_

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**Have you ever become violent or destructive? Have you ever hurt an animal or person intentionally, or threatened to harm or kill someone?** \_\_\_\_\_

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**What problems, if any, have you had with authority, with getting into trouble, or with behaviors or actions that could cause legal problems?** \_\_\_\_\_

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Have you ever thought about or attempted suicide? If yes, please describe. \_\_\_\_\_

**FAMILY/SOCIAL ISSUES**

Who is living in your home? Please describe your relationship with your family- parents, children, significant other: \_\_\_\_\_

Briefly describe your relationship with you friends and peers? Are you happy with this area of your life? \_\_\_\_\_

Briefly describe your relationship with your employer and coworkers? \_\_\_\_\_

Have you experienced any recent disruptions in your life, including family crisis, conflicts, grief or other loss, financial problems, job difficulties, etc.? Please explain. \_\_\_\_\_

Is there any history of abuse or trauma in your background? No \_\_\_ Yes \_\_\_ Please explain.

What are the stressors in your life? \_\_\_\_\_

From whom/what do you find support? \_\_\_\_\_

What are your strengths? \_\_\_\_\_

## LIFESTYLE

Please describe your sleep habits including how long it takes you to fall asleep, how many times you wake during the night, and if you go to sleep and wake on a regular schedule: \_\_\_\_\_

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Please check any of the following sleep problems you have now or have experienced in the past, and explain below.

\_\_\_\_\_ Difficulty waking in the morning

\_\_\_\_\_ Difficulty falling asleep

\_\_\_\_\_ Not rested after sleep

\_\_\_\_\_ Frequent waking during the night

\_\_\_\_\_ Nightmares/ bad dreams

\_\_\_\_\_ Snoring

\_\_\_\_\_ Sleeping too much

\_\_\_\_\_ Teeth grinding

\_\_\_\_\_ Sleep apnea (stops breathing)

\_\_\_\_\_ Restless legs

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What types of exercise do you enjoy, and for how many hours per week? \_\_\_\_\_

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What, if any, problems have you had with food cravings, food aversions or sensitivities, dieting, or maintaining weight? Have you tried any particular dietary restrictions or supplements? \_\_\_\_\_

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What area of your nutrition could be improved? \_\_\_\_\_

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How many caffeinated beverages (coffee, tea, cola, etc.) do you drink per day? \_\_\_\_\_

What is your reaction to caffeine or stimulants such as decongestants? \_\_\_\_\_

Do you use sugar substitutes and if yes, which type? No \_\_\_ Yes \_\_\_\_\_

Do you drink alcohol? No \_\_\_ Yes \_\_\_ If yes, how many per day? \_\_\_\_\_ per week \_\_\_\_\_

What is your reaction to alcohol or other depressants? \_\_\_\_\_

Have you ever had any legal, job related, or family problems involving alcohol? \_\_\_\_\_

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Do you currently smoke or use tobacco? No \_\_\_ Yes \_\_\_ What type and how much per day? \_\_\_\_\_

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If no, did you use tobacco in the past and if so, how much for how long? \_\_\_\_\_



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**What are you specifically hoping to achieve or address with us?** \_\_\_\_\_

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**THANK YOU for all your time and effort in completing this lengthy form. We really do appreciate receiving the information we need to understand how each individual client is challenged and gifted. Please bring any other records, test results, school results, or pertinent information to your appointment. We look forward to working with you.**