

The Pisgah Institute for Psychotherapy and Education, P.A.

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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? _____

What other concerns do you have? _____

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 _____

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? _____

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

Do you have any environmental allergies, food or medication sensitivities? _____

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:** _____

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? _____

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: _____

Highest educational level completed? _____

Current employment _____

Previous employment history: _____

BEHAVIORAL ISSUES

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

- | | | |
|-------------------------------------|--------------------------|-------------------------------------|
| _____ Inattention | _____ Distractibility | _____ Anger tantrums |
| _____ Impulsivity | _____ Depression | _____ Compulsive behavior |
| _____ Irritability | _____ Agitation | _____ Muscle/ Verbal Tics |
| _____ Anxiety | _____ Fears | _____ Lack of remorse |
| _____ Obsessive
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 |
-
-
-

What conditions or triggers seem to worsen your condition? _____

What helps to calm you? _____

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

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

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: _____

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 |
-
- _____
-
- _____

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

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? _____

What area of your nutrition could be improved? _____

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? _____

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

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

What are you specifically hoping to achieve or address with us? _____

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.