GHP Counseling Services
222 Government Ave, Suite E
Niceville, FL 32578
Phone (850) 659-3550

Adult Psychosocial/Intake Assessment

I. Personal Information:

Today's Date:_____

Name: _____ SSN: _____

Address: _____

Date of Birth: _____ Age: _____

E-mail _____ Permission to contact via e-mail: ___ Y ___ N

Home Phone: _____ Cell Phone Number: _____

May I contact and leave detailed voice messages? ___ Y ___ N

When are the best days and times to reach you? _____

Spouses Name: _____ SSN: _____

Address: _____

Date of Birth: _____ Age:_____

E-mail _____ Permission to contact via e-mail: ___ Y ___ N

Primary Phone Number: _____ Alternate Phone Number: _____

May I contact and leave detailed voice messages? ___ Y ___ N

When are the best days and times to reach you? _____

If you are currently employed, where do you work and what is your current position?

_____

_____

II. Chief Concerns:

Are you required to enter mental health treatment? ___ Y ___ N

If yes, by whom? _____

Please check the issues for which you are seeking treatment:

_____ Depression _____ Anxiety _____ Relationship Issues

_____ Suicidal Thinking _____ Anger Problems _____ Parenting Issues

_____ Grief & Loss Issues _____ Guilt _____ Sexual Issues

_____ Alcohol/Drug Use _____ Divorce/Separation concerns _____ Medical Issues

_____ Work Issues _____ School Problems _____ Legal Issues

_____ Other: _____

Please describe in your own words the primary issue(s) for which you are seeking counseling: _____

(*cont.*)_____

_____

How long has/have the current problem(s) existed? _____

How frequently do these problems occur? _____

Have these problems gotten worse since they began?: _____yes _____no

Are these problems present at: _____Home _____School _____Work _____W/ Others

Have these problems ever decreased or gone away?: _____yes _____no

If yes, please describe: _____

_____

_____

What, if anything, have you done to cope with the problems for which you are seeking help?

_____

_____

_____

Client Name:_____ Client ID:_____

III. Current Problem Description:

Please check the **behaviors** which **currently** apply to you:

_____Frequent Crying _____Hyperactive Behavior

_____Self-Neglect _____Working Too Much

_____Loss Of Interest In Previously Enjoyable Activities _____Temper Outbursts

_____Trouble Concentrating _____Drinking Too Much

_____Withdrawing From Others _____Drug Abuse

_____Eating Too Much _____Eating Too Little

_____Purging _____Skipping Meals

_____Sleeping Too Much _____Trouble Falling Asleep

_____Trouble Staying Asleep _____Nightmares

_____Flashbacks _____Cutting/Self-Mutilation

_____Other:_____

Please check the **feelings** which **currently** apply to you:

_____Restless _____Sad _____Lonely _____Worthless

_____Nervous _____Confused _____Overwhelmed/Stressed

_____Helpless _____Moody _____Like A Failure

_____Angry _____Distrustful _____Ashamed

_____Panicky _____Unattractive _____Fearful

_____Irritable _____Annoyed _____Unmotivated _____Other

Please check the **physical symptoms** which **currently** apply to you:

_____Stomachaches _____Racing Thoughts _____ Numbness/Tingling

_____Headaches _____Dizziness _____Loss of Sex Drive

Client Name:_____ Client ID:_____

_____Back Pain _____Heart Pounding _____Appetite Changes

_____Tremors/Shakiness _____Chest Pain _____Weight Loss/Gain

_____Fainting Spells _____Blackouts _____Other:_____

IV. Medical History:

With a score of 1 being *poor* and 10 being *excellent*, how would you rate your current health?: 1 2 3 4 5 6 7 8 9 10

Do you currently have a primary physician? ___ Y ___ N

If yes, whom? _____

Date of last physical exam? _____

Are you currently taking medication? ___ Y ___ N

Medication	Taken For	Date Begun	Dosage	Frequency	Prescribing Doctor

Are you **currently** being treated for any medical problems?: _____yes _____no

If yes, explain: _____

_____

V. Behavioral Health History:

Are you **currently** being seen by a psychiatrist?: _____yes _____no

If yes, name of provider/facility_____

Client Name:_____ Client ID:_____

Location:_____

Frequency:_____

Reason:_____

Date of Last Visit:_____

Are you **currently** attending mental health counseling?: _____yes _____no

If yes, name of provider/agency:_____

Location:_____

Frequency:_____

Reason:_____

Date of Last Visit:_____

Have you received counseling and/or psychiatric treatment in the past?: _____yes _____no

Dates of Treatment	Name of Provider/Facility	Type of Counseling (individual, group, etc)	Inpatient or Outpatient ?	Reason for treatment?	Did you complete treatment?

Have any family members ever experienced a mental illness? ___ Y ___ N

If yes, please explain: _____

_____

_____

Do you **currently have** or have you **recently had** thoughts about harming yourself or committing suicide? ___ Y ___ N (use back side of form if needed)

If yes, describe:_____

Client Name:_____ Client ID:_____

Have you ever attempted suicide? ___ Y ___ N

If yes, when? _____

How? _____

Did this require medical treatment? ___ Y ___ N

Do you **currently have** or have you **recently had** thoughts of harming another? ___ Y ___ N

If yes, describe: _____

Have you ever attempted to harm another? ___ Y ___ N

If yes, how?:_____

VI. Substance Use History:

Have you ever used tobacco? ___ Y ___ N

If yes, type(s) used _____

How often do you use tobacco?:_____

Age of first use:_____ Age of regular use: _____ When was your last use?:_____

Has your tobacco use ever caused you problems?: _____yes _____no

If yes, explain:_____

Are you interested in quitting? ___ Y ___ N

Ready to stop rating? 0 (not ready) to 10 (ready) _____

Have you ever used alcohol? ___ Y ___ N

If yes, type(s) used:_____

How often do you use alcohol?:_____

Age of first use:_____ Age of regular use: _____ When was your last use?:_____

Has your alcohol use ever caused you problems? ___ Y ___ N

Client Name:_____ Client ID:_____

If yes, explain:_____

Have you ever used mood altering drugs (marijuana, cocaine, crack, etc? ___ Y ___ N

If yes, type(s) used: _____

How often do you use them? _____

Age of first use: _____ Age of regular use: _____ Last time used? _____

Has your drug use ever caused you problems? ___ Y ___ N

If yes, explain:_____

VII. Current Family/Relationship Information:

Please check the option that best reflects your current relationship status.

_____Never married and not currently in a serious relationship
_____Never married but in a serious relationship
_____Currently married and living with my spouse
_____Currently married but separated from my spouse
_____Currently divorced and single
_____Currently divorced but in a serious relationship
_____Currently widowed and single
_____Currently widowed but in a serious relationship

Please list the name, age, parents' names and city/state of residence for each of your children:

Child's Name	**Child's Age**	**Parents' Names**	**Child's Current City/State of Residence**

Client Name:_____ Client ID:_____

Please list anyone else (excluding the children listed above) whom you consider to be a source of social/emotional support for you. Please indicate whether they currently live with you and their relationship to you.

Do you **currently feel safe** at home? ___ Y ___ N

Does your **current romantic partner tell you how much money to spend, where you can go, who you can spend time with, or otherwise determine aspects of your life?** ___ Y ___ N

Has your **current romantic partner** ever **called you names, or threatened to harm him/herself or others if you didn't do what he/she said?** ___ Y ___ N

Has your **current romantic partner** ever **threatened to hit, punch, strangle, or otherwise physically harm you?** ___ Y ___ N

Has your **current romantic partner** ever **hit, punched, strangled or otherwise physically harmed you?** ___ Y ___ N

Has your **current romantic partner** ever **threatened to force, attempted to force, or forced you to do sexual things** you didn't want to do? ___ Y ___ N

VIII. Your Family of Origin:

Who primarily raised you?:_____

What is his or her/their relationship to you?:_____

If you experienced significant changes growing up, such as the death of a loved one, a divorce, or separation from a primary caregiver, please describe these changes below and list how old you were when they occurred: _____

_____

_____

Do you have brothers and/or sisters? ___ Y ___ N

If yes, # of brothers: _____ # of sisters: _____

# of half brothers: _____ # of half sisters _____

# of step brothers: _____ # of step sisters: _____

Has there ever been a time **when adults who were supposed to be taking care of you did not?** ___ Y ___ N

Client Name:_____ Client ID:_____

Growing up, did **parents or caregiver call you names or put you down?** ___ Y ___ N

Has a **family member or caregiver** ever **threatened to physically harm you?** ___ Y ___ N

Have you ever been **hit, kicked, shoved, strangled, or otherwise physically harmed by a family member or caregiver?** ___ Y ___ N

Has a **family member or caregiver** ever **tried to make you do sexual things you didn't want to do, like touch you, make you touch them, attempted to have sex with you, or forced you to have sex?** ___ Y ___ N

XI. Your Strengths, Weaknesses, and Treatment Goals and Preferences:

My strengths: _____

My weaknesses: _____

I hope counseling will help me: _____

_____

Do you have any preferences for treatment, such as preferred days, appointment times, or treatment activities? _____

_____

Any additional information you wish to share? _____

_____

Please list your goals for counseling

1) _____

2) _____

3) _____

4) _____

Client Name:_____ Client ID:_____