RENEE ESPINOLA, LICSW

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Adult Assessment

Today's Date: _____ Referred By: _____

Name of Client: _____ DOB: _____ Age _____ Gender F M

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell: _____

Leave message: Home # Y ___ N ___ Work # Y ___ N ___ Cell # Y ____ N _____

Email Address: _____

Primary Health Insurance Co.: _____

ID: _____ Group #: _____

Provider Services Tel # (back of card) _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Client: _____ Subscriber Employer: _____

Secondary Health Insurance Company: _____

ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Client: _____

Emergency Contact: _____ Relationship to Client: _____

Tel # _____ Cell # _____

Is person aware client is seeking services? Y ____N ____

**** Please note that by providing Renee Espinola, LICSW with this emergency information, you are giving permission to contact this person in an emergency.**

Why have you decided to seek counseling at this time?

_____

What are your goals of therapy?

_____

Psychiatric History: Have you been in therapy before? Yes No

List current and/or previous therapist: Therapist _____

Dates of Treatment: _____ Symptoms _____

Current psychiatric medications: _____

Prescriber of these medications: _____ Tel #: _____

Have you been hospitalized for psychiatric symptoms? Yes No

Date(s) of Hospitalization: _____ Hospital: _____

Reason: _____

Place a ✓ next to any current symptom.

	Anxious mood		Irritability		Frequent mood swings
	Depressed mood		Easily Distracted		Difficulty focusing on tasks
	Feeling "stressed"		Unable to work		Excessive worry
	Sadness/Emptiness		Unable to fulfill responsibility		Gambling
	Hopeless		Recent/grief		Overspending
	Decreased appetite		Chronic fatigue		Reckless behavior
	Inability to fall/stay asleep		Heart racing/chest pain		Overspending
	Isolate/withdraw		Loss of interest in activities		Nightmares
	Fear of crowds		Lose track of time		Recent medical diagnosis
	Fear of going out		Fear of dying		Nausea/Diarrhea
	Phobias (animals, heights)		Feel detached/unreal		Headaches/physical
	History of black outs		Lack of energy		Heart racing/Chest Pain
	Facing legal charges		Poor concentration		Binging/Purging
	Use of alcohol or drugs		Forgetful/Often lose things		Self harm (cut, burn)
	Feel numb		Verbally abusive to others		Weight gain/loss
	Excessive guilt		Constant worry		Fear of social situations

Thinking about the past 2 weeks, rate severity of symptoms (0= no symptoms, 10 = most severe ever)

__ Angry __Depressed __Anxious/Stressed __Use of Drugs/Alcohol ___Suicidal Thoughts __Other

Have you ever thought of hurting yourself or that you did not want to live anymore? Yes No

Have you ever thought of a plan to commit suicide? Please explain: _____

_____

Have you ever thought of wanting to hurt someone else? Yes No

Have you ever thought of plan to hurt someone else? Please explain: _____

_____

Medical Information:

Primary Care Physician: _____ Date of Last Physical _____

Tel # _____

List any medical conditions or recent illness:

_____

Do you exercise? Yes No How much/week? _____

Do you smoke? Yes No How much/day? _____

Do you drink coffee or other caffeinated drinks daily? If yes, how much each day? _____

List any/all allergies: _____

Marital/Family/Social History:

Who lives with you? Partner/Spouse Children Parent(s) Relative(s) Roommate(s) Other(s)

Marital Status: (circle) Single Married Separated Divorced Widowed In a Relationship

Marriages: _____ Date of marriage: _____ Date of separation/divorce: _____

Do you have any marital/relationship concerns?_____

Do you feel safe at home? Yes No If no, explain: _____

Religion: (if applicable) _____ Do you practice or attend services? Yes No

Community/Social/Group involvement: _____

Children:

Name	Age	Live with you	Biological Child	Adopted	Step-Child	Have Custody

Deceased Children: Yes No

Please explain: _____

Is DCF (Dept. of Children and Families) involved? Yes No

Explain: _____

DCF: Office: _____ Case Worker: _____

Education History: √ Highest Level of Education Completed.

__ Some High School __ High School __GED/Other __Some College __College __Post-Grad

If in school now, where? _____ Major: _____

Are current psychiatric or medical issues interfering with your ability to attend school? Yes No

Vocational History:

Are you currently employed: Yes No Where: _____

Current position? _____ How long have you been there? _____ # hours/week: ____

Do you enjoy this job? Never ___ Occ. __ Usually ___

Describe your relationship with your current supervisor/boss:

Difficult: __ Manageable __ Enjoyable: __

If unemployed, for how long: _____ Reason for unemployment: _____

Are current psychiatric or medical issues interfering with your ability to work? Yes No

Do you receive Social Security Disability Income (SSDI), Unemployment or Workman's Comp? Yes No

Have you ever served in the military? Yes No

If yes, When: _____ Branch: _____ Discharge Status: _____

Substance Use/Gambling/Addiction History:

Lost a job, become disorderly, fought, or got into trouble while using substances?	Yes	No
Considered yourself to have an addiction or need treatment?	Yes	No
Lost friends or relationships due to an addiction?	Yes	No
Attended AA, NA or other self-help groups?	Yes	No
Prior DUI (Driving Under the Influence)	Yes	No
Using alcohol, drugs, internet or video games?	Yes	No
Borrowed money to gamble or cover lost money?	Yes	No
Thought you might have a gambling problem or told you might?	Yes	No
Hid your use of addiction(s) from others?	Yes	No

Do you own a firearm/weapon AND/OR is one in your home? If yes, what _____ Yes No

Are you involved in any legal issues at this time? Yes No

	Specify Drugs Used	Date Last Used	Age of First Use	Frequency
Alcohol				
Amphetamines				
Benzodiazepines				
Opiates				
Marijuana				
Prescription Drugs				
Other:				
Internet Addiction				
Sex Addiction				
Video Games				

Current Supports: (circle all that apply)

Family Friends Co-workers Religion Community/Group Pets Other _____

Current Stressors: (circle all that apply)

Primary Supports (family, relational) Social Access to Healthcare Financial Occupational Educational Housing Legal Physical Issues Psycho-Social/Environmental (discord with non-family, war) Other _____

Hobbies/Interests:

_____

Additional information:

_____

Thank you for taking the time to complete this important assessment.