Adult Mental Health Assessment

Confidential

By completing this assessment, you will be helping the therapist have a better understanding of where you currently are in major areas of development, such as: attachment, physical, emotional, cognitive, social, and sexual. This assessment also contains questions about safety concerns, illegal substance use, and legal issues. For the check boxes, type "x" in the box to mark it. Boxes that are dashed are there for you to provide additional information if needed.
Please note that the thick green boxes are for the therapist to fill out.

Section 1: Client Information

Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Male/Female

Race/Ethnicity:

☐ Caucasian ☐ African American ☐ Asian ☐ American Indian or Alaskan Native

☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Other: _____

What type of therapy are you seeking? (check all that apply)

☐ Individual ☐ DBT ☐ Attachment Classes ☐ Neurofeedback

☐ Family Therapy ☐ Marital/Couple Therapy ☐ Social Skills Group ☐ Other: _____

Why are you seeking therapy at this time?

Section 2: Childhood Development History

Problems During Mother's Pregnancy:

☐ None ☐ High Blood Pressure ☐ Kidney Infection ☐ Other:

☐ Drug Use ☐ Emotional Stress ☐ German Measles ☐ Other:

Birth:

☐ Normal Delivery ☐ Caesarean Section (C-Section) ☐ Difficult Delivery ☐ Complications:

Birth Weight: _____ lbs. _____ oz. Birth Height: _____ inches Weeks of Gestation: _____

Adult Mental Health Assessment

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Childhood Health (if there was a problem, please write the age it occurred at)**:**

Problem		Age	Problem		Age
☐ No	☐ Yes	___ Feeding	☐ No	☐ Yes	___ Sleep Problems
☐ No	☐ Yes	___ Developmental Delays	☐ No	☐ Yes	___ Asthma
☐ No	☐ Yes	___ Toilet Training Issues	☐ No	☐ Yes	___ Chicken Pox
☐ No	☐ Yes	___ Chronic Health Problems	☐ No	☐ Yes	___ Red Measles
☐ No	☐ Yes	___ Serious Health Problems	☐ No	☐ Yes	___ Rheumatic Fever
☐ No	☐ Yes	___ Significant Injuries	☐ No	☐ Yes	___ Lead Poisoning
☐ No	☐ Yes	___ Whooping Cough	☐ No	☐ Yes	___ Tuberculosis
☐ No	☐ Yes	___ Scarlet Fever	☐ No	☐ Yes	___ Low IQ
☐ No	☐ Yes	___ Autism	☐ No	☐ Yes	___ Drug Use
☐ No	☐ Yes	___ Ear Infections	☐ No	☐ Yes	___ Cigarette Use
☐ No	☐ Yes	___ Mumps	☐ No	☐ Yes	___ Other: _____
☐ No	☐ Yes	___ Diphtheria	☐ No	☐ Yes	___ Other: _____
☐ No	☐ Yes	___ Polio	☐ No	☐ Yes	___ Other: _____
☐ No	☐ Yes	___ Pneumonia	☐ No	☐ Yes	___ Other: _____
☐ No	☐ Yes	___ Allergies	☐ No	☐ Yes	___ Other: _____

Delayed Developmental Milestones During Childhood (check if you are aware that they did not occur)**:**

☐ Sitting	☐ Speaking Words	☐ Dressing Self	☐ Riding a Bicycle
☐ Rolling Over	☐ Speaking Sentences	☐ Engaging with Peers	☐ Other: _____
☐ Standing	☐ Controlling Bladder	☐ Tolerating Separation	☐ Other: _____
☐ Walking	☐ Controlling Bowels	☐ Playing Cooperatively	☐ Other: _____
☐ Feeding Self	☐ Sleeping Alone	☐ Riding a Tricycle	☐ Other: _____

Emotional/Behavioral Problems During Childhood:

☐ Drug Use	☐ Assaulting Others	☐ Self-Injurious Threats	☐ Easily Distracted
☐ Alcohol Use	☐ Disobedient	☐ Self-Injurious Acts	☐ Poor Concentration
☐ Chronic Lying	☐ Repeats Words of Others	☐ Frequently Tearful	☐ Often Sad
☐ Stealing	☐ Not Trustworthy	☐ Frequently Daydreams	☐ Breaks Things
☐ Violent Temper	☐ Hostile/Angry Mood	☐ Lack of Attachment	☐ Other: _____
☐ Fire-setting	☐ Indecisive	☐ Distrustful	☐ Other: _____
☐ Hyperactive	☐ Immature	☐ Extreme Worrier	☐ Other: _____
☐ Animal Cruelty	☐ Bizarre Behavior	☐ Impulsive	☐ Other: _____

Social Interactions During Childhood (check all that apply)**:**

☐ Normal Social Interaction	☐ Very Shy	☐ Inappropriate Sex Play	☐ Acting-Out with peers
☐ Isolates Self	☐ Alienates Self	☐ Dominate Others	☐ Authority Conflicts

Intellectual/Academic Development During Childhood (check all that apply)

☐ Normal Intelligence	☐ Attention Problems	☐ Other: _____
☐ High Intelligence	☐ Underachieving	
☐ Learning Problems	☐ Problems with Adapting to Change	

Childhood Family Social/Economic Statu

☐ Wealthy ☐ Middle Class ☐ Working Class ☐ Poor

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Confidential

Father	Mother	Siblings & Age
Full Name: _____	Full Name: _____	_____
Occupation: _____	Occupation: _____	_____
Education: _____	Education: _____	_____
Health: _____	Health: _____	_____

Describe Overall Childhood Family Experience (please check all that apply)**:**

- ☐ Safe, Warm, Supportive
- ☐ Adequate, Average, Basic needs met
- ☐ Inconsistent or Chaotic Environment
- ☐ Experienced Physical/Emotional/Sexual Abuse
- ☐ Saw Physical/Emotional/Sexual Abuse
- ☐ Other: _____
- ☐ Neglect
- ☐ Limited Memory

Mark how present your family members where during your childhood (If it's not applicable please mark "NA")**:**

Person	Entire Childhood	Most of Childhood	Part of Childhood	Absent	If you marked "Absent" do you know the reason why?
Mother	____	____	____	____	_____
Father	____	____	____	____	_____
Stepmother	____	____	____	____	_____
Stepfather	____	____	____	____	_____
Brother(s)	____	____	____	____	_____
Sister(s)	____	____	____	____	_____
Grandparents - Mother side	____	____	____	____	_____
Grandparents - Father side	____	____	____	____	_____
Other: _____	____	____	____	____	_____

Client's Parents Current Status:

- ☐ Parents never married
- ☐ Married to each other for ____ # of years
- ☐ Separated for ____ # of years
- ☐ Divorced for ____ # of years
- ☐ Mother remarried ____ # of years
- ☐ Father remarried____ # of years
- ☐ Mother involved with someone ____ # of years
- ☐ Father involved with someone ____ # of years

Mother deceased for ____ # of years Client Age at Death: _____

Father deceased for ____ # of years Client Age at Death: _____

Age of emancipation from home (if applicable)**:** ____ **Circumstances:**

Is there anything else your therapist should know about?

Section 3: Physical Health

Concern	Severity 0,1,2,3,4,5	Concern	Severity 0,1,2,3,4,5	Concern	Severity 0,1,2,3,4,5
Poor Appetite		Knot in Stomach		Inability to Relax	
Change in Appetite		Grinding Teeth		Tics	
Difficulty Falling Asleep		Back Pain		Other:	
Difficulty Staying Asleep		Muscle Aches		Eating Problems	
Tiredness/Fatigue		Upset Stomach		Physical Abuse	
Sleeping Too Much		Chest Pain		Sleep Disorder(s)	
Weight Gain		Shakiness		Head Trauma	
Weight Loss		Jumpiness		Memory Problems	
Heart Racing		Heart Pounding		Diagnosed Illness	
Twitches/Spasms		Light Headedness			

Please explain any other concerns your therapist should know about?

Section 4: Emotional Health

Concern	Severity 0,1,2,3,4,5	Concern	Severity 0,1,2,3,4,5	Concern	Severity 0,1,2,3,4,5
Depressed Mood		Loss of Interest in Things		Death/Grief/Loss	
Worrying		Temper Outbursts		Depression	
Angry Feelings		Cry Easily		Emotional Abuse	
Angry Behavior		Thoughts of Hurting Myself		Low Self Esteem	
Feeling Anxious/Nervous		Thoughts of Killing Myself		Stress	
Panic Attacks		Guilty Feelings		Obsessions	
Sweaty Palms		Social Withdrawal		Compulsions	
Easily Annoyed/Irritated		Feel I'm Being Watched		Behavioral Issues	
Lump In Throat		Fear of Places		Emotional Issues	
Feel Others are Against Me		Anxiety			

Please explain any other concerns your therapist should know about?

Section 5: Cognitive Health

Concern	Severity 0,1,2,3,4,5	Concern	Severity 0,1,2,3,4,5
Difficulty Concentrating		Autism/Asperger's	
Mind Going Blank		Learning Disabilities	
Hearing/Seeing Things		Dementia	
Thoughts Coming to Fast		Alzheimer's	
Trouble with Memory			
Distractibility			
Impatience			
Change in Grades			
Nightmares			
ADHD			

Please explain any other concerns your therapist should know about?

Section 6: Sexual Health

Sexual Orientation:
☐ Heterosexual ☐ Homosexual ☐ Lesbian ☐ Bisexual ☐ Transsexual ☐ Questioning

Are you currently sexually* active:
☐ No ☐ Yes If "Yes" are you… ☐ Sexually Satisfied ☐ Sexually Dissatisfied ☐ Having Sexual Difficulty

Number of sexual* partners starting from your first sexual experience until today: _____ # of Sexual Partners

Do you have a history of:

Promiscuity	☐ Yes	☐ No
Unsafe Sex*	☐ Yes	☐ No
Abortion	☐ Yes	☐ No
Miscarriage	☐ Yes	☐ No
Sexual Abuse	☐ Yes	☐ No

Age at 1st sexual experience: _____ **Age at 1st Pregnancy/Fatherhood:** ____

Current/Previous history of a Sexually Transmitted Disease? ☐ No ☐ Yes

If "Yes", which one(s):

Date of Last Gynecological Exam: _____

*Sex/Sexual Activity is defined as follows: Vaginal, Oral, or Anal; whether a condom or other protection is/was used.

Please explain any other concerns your therapist should know about?

Section 7: Legal History

☐ If there is no legal history, please check the box to the left and proceed on to Section 8: Relationship/Marriage

☐ On Parole/Probation ☐ Arrest(s) Substance-Related ☐ Jail/Prison: _____ # of times
☐ Arrest(s) Not Substance-Related ☐ Court Ordered This Treatment Total Timed Served: _____
Years/Months

Please explain any legal difficulty that your therapist should know about

Section 8: Relationship/Marriage History

Current Relationship Status:

☐ Single, Never Married ☐ Single, Previous Marriage ☐ Engaged: ____ months Wedding Date: _____
☐ Married How many years/months? _____ ☐ Cohabiting How many years/months? _____
☐ Never Been in a Serious Relationship ☐ Not in a Serious Relationship Date of last serious relationship: _____
☐ In a Serious Relationship Length of Time: _____

Relationship Concerns:

☐ Past Family Problems ☐ Family Relationships ☐ Marital Issues ☐ Divorce
☐ Romantic Relationships ☐ Domestic Violence ☐ Child

If previously Married or Cohabited, please answer the following

Marriage/Cohabitated #1: _____ years Divorce/Breakup #1 year: _____ Reason: _____
Marriage/Cohabitated #2: _____ years Divorce/Breakup #1 year: _____ Reason: _____
Marriage/Cohabitated #3: _____ years Divorce/Breakup #1 year: _____ Reason: _____
Marriage/Cohabitated #4: _____ years Divorce/Breakup #1 year: _____ Reason: _____

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People Currently Living with You

Name	Age	Sex (M or F)	Relationship to You

Attachment Style:

Check the white box for each statement that is TRUE for you. If the answer is untrue, don't mark anything & move on.

	A	B	C
I often worry that my partner will stop loving me			
I find it easy to be affectionate with my partner			
I fear that if someone new the real me, he/she won't like who I am			
I find that I can easily walk away from a relationship. It's weird how I can just put someone out of my mind			
If I feel someone is rejecting me, I feel somewhat anxious and incomplete			
I find it exhausting to support my partner when he/she is feeling down.			
When my partner is away, I'm afraid that he/she might loving me			
I feel comfortable depending on romantic partner			
My independence becomes more important to me than my relationships			
I find that I do not share my feelings often			
When I share my emotions, it will be off putting to my partner			
I am generally satisfied with my romantic relationship			
I don't feel I need a meltdown to get my partner's attention			
I think about my relationships a lot			
I find it difficult to depend on romantic partner			
In dating, I tend to get very quickly attached to a romantic partner			
It seems for me that I have little difficulty expressing my needs and wants to my partner			
I get easily irritated with my partner, and I don't know why			
I am very sensitive to my partner's moods, and tend to take it personally			
I believe most people are essentially honest and dependable			
I find myself preferring casual relationships and yet long for intimacy			
I'm comfortable sharing my personal thoughts and feelings with my partner			
I worry that if my partner leaves me I might never find someone else			
I often feel smothered by my partner			
During a conflict, I tend to impulsively do or say things I later regret, rather than be able to reason about things			
An argument with my partner doesn't usually cause me to question our entire relationship			
My partner often tells me I'm being distant			
I worry that I'm not attractive enough			
I feel comfortable and safe and rarely get upset in a relationship			
I miss my partner when we're apart, but when we're together I feel the need to have space			
When I disagree with someone, I feel comfortable expressing my opinions			
I hate feeling that other people have expectations of me			

If I notice that someone I'm interested in is checking out other people, I don't let it faze me. I might feel the pang of jealousy, but it's fleeting			
I have a history of allowing myself to be talked into physical intimacy to maintain a relationship			
If I notice that someone I'm interested in is checking out other people, it makes me feel anxious and leads to a fight			
When my partner begins to act cold and distant, I may wonder what's happened, but I'll know it's probably not about me			
When my partner begins to act cold and distant, I'll probably be indifferent—maybe even relieved			
When my partner begins to act cold and distant, I'll worry that I've done something wrong			
If my partner was to criticize me, I'd try my best to show him/her that I'm unaffected			
If someone I've been dating for several months told me they want to break up, I'd feel hurt, but get over it			
I often find myself feeling critical towards my partner and wondering if I made a mistake			
I seldom break off relationships—after all we have a lot in common			

Add up all your checked boxes for columns: **A**_____ **B**_____ **C**_____

Please explain any other concerns your therapist should know about?

Section 9: Spirituality

☐ Yes ☐ No **Do you feel that you have a purpose in life?**
☐ Yes ☐ No **Do you believe in a power greater than yourself?**
☐ Yes ☐ No **Do you feel that your morals, beliefs & values have been compromised due to alcohol/drug use?**
☐ Yes ☐ No **Were you raised with a religion as a child?**
☐ Yes ☐ No **Do you have a religion that you currently practice?**
If "Yes", will you please list it here: _____
☐ Yes ☐ No **Do you currently practice any spiritual activities such as praying, attending church, member of choir, reading, mass, meditation, journaling?**
If "Yes", will you please list activities:

Briefly describe what "God" or a "Higher Power" means to you:

Please explain any other concerns your therapist should know about?

Section 10: Medical History

Describe current physical health (check one) **:** ☐ Good ☐ Fair ☐ Poor

Date of Last Physical Exam: _____

Do you take any medication? ☐ No ☐ Yes **If "Yes", please fill in the table for ALL medications you take:**

Name of Medication	Dosage (mg)	Frequency	Prescribed For	Prescribing Physician	Date Began

Is there a history of any of the following in the family (check all that apply) **:**

☐ Tuberculosis	☐ Cancer	☐ Drug Abuse	☐ Other: _____
☐ Birth Defects	☐ Mental Retardation	☐ Diabetes	☐ Other: _____
☐ Emotional Problems	☐ Heart Disease	☐ Alzheimer's/Dementia	☐ Other: _____
☐ Behavior Problems	☐ High Blood Pressure	☐ Schizophrenia	☐ Other: _____
☐ Thyroid Problems	☐ Alcoholism	☐ Stroke	☐ Other: _____

Describe any serious accidents or major surgeries:

Date	Age	Problem	Reason

List any significant health problems you have been treated for in the past:

Date Treated	Problem	Current Status

Allergies (check all that apply and if "Yes", please list what) **:**

☐ No	☐ Yes	Food Allergies:
☐ No	☐ Yes	Medication Allergies:
☐ No	☐ Yes	Latex:
☐ No	☐ Yes	Environmental:
☐ No	☐ Yes	Animal:
☐ No	☐ Yes	Other:
☐ No	☐ Yes	Other:

Males Only

Have you had problems in the past or are you presently having problems with your prostate, difficult or painful urination, or impotence? If "Yes", please describe the problem(s):

☐ No ☐ Yes

Females Only

Age at first menstruation: _____ yrs. old

Have you ever had problems with your period? If "Yes", please explain: ☐ No ☐ Yes

Have you had any…

	How Many?	Date(s)
Pregnancies	_____	_____
Miscarriages	_____	_____
Abortions	_____	_____

Please explain any other concerns your therapist should know about?

Section 10: Psychiatric History

Have you ever been in counseling before? ☐ No ☐ Yes **If "Yes", please list your previous counseling agencies:**

Name of Counselor/Agency	Counselor/Agency Address	Counselor Phone #	Years Seen	Approx. # of Times

Have you ever been hospitalized for a psychiatric or substance abuse disorder? ☐ No ☐ Yes

If "Yes", please list your previous hospitalization:

Name of Agency	Agency's City & State	Agency Phone #	Date of Admission	Reason for Admission	Date of Discharge

Please explain any other concerns your therapist should know about?

Section 11: Family Concerns

Please explain any concerns your therapist should know about?

Section 12: Family Strengths

Please explain any strengths your therapist should know about?

Section 13: Comprehensive Clinical Summary

Comprehensive Clinical Summary (Therapist Section)

Section 14: Diagnostic Impression

Section 15: Therapeutic Recommendations

Therapy Type (check all that apply): ☐ Individual ☐ Family ☐ Group ☐ Neurofeedback

Therapeutic Recommendations (Therapist Section)

Therapist (Replace this line with your name and licensure) _____ Date _____

Supervisor (Replace this line with your supervisor & licensure, if needed) _____ Date _____