PREASSESSMENT FOR ADULTS

Name: _____ DOB: _____ Date: _____

What is your reason for your visit?

_____

Briefly describe the events that led to this appointment:

_____

_____

What are your goals for the evaluation and/or treatment?

_____

Symptoms

Check if applicable	Current	Ever
Nervousness/tension	☐	☐
Excessive worries or fears	☐	☐
Anxiety attacks	☐	☐
Avoidance	☐	☐
Repetitive thoughts or behaviors	☐	☐
Rigid routines	☐	☐
Perfectionistic	☐	☐
Concerns about eating habits or weight	☐	☐
Food binging or self-induced vomiting	☐	☐
Fatigue/low energy	☐	☐
Racing thoughts	☐	☐
Difficulty focusing to complete tasks	☐	☐
Easily distracted	☐	☐
Irritability	☐	☐
Hopeless/don't care	☐	☐
Persistent negative or worry thoughts	☐	☐
Self-harm (cutting, burning, etc.)	☐	☐
Isolating or withdrawal from others	☐	☐

Check if applicable	Current	Ever
Depressed mood	☐	☐
Loss of enjoyment in usual activities	☐	☐
Loss of interest	☐	☐
Poor concentration/forgetful	☐	☐
Change in appetite	☐	☐
Change in sleep	☐	☐
Nightmares	☐	☐
Excessive guilt	☐	☐
Crying spells	☐	☐
Change in sex drive	☐	☐
Excessive energy	☐	☐
Decreased need for sleep	☐	☐
Feel invincible like you can do anything	☐	☐
Mood swings/mood changes without reason	☐	☐
Loss of inhibition (risky behavior, hypersexual)	☐	☐
Unusual thoughts or peculiar ideas	☐	☐
Hearing or seeing things that others don't	☐	☐
Aggressive verbally or physically	☐	☐

Impulsivity (blurting things out, act without thinking, antsy, fidgety ..... ☐ ☐

Where are these problems present? Home ☐ Work ☐ School ☐ Other ☐ Comments _____

(Continued on back side)

Have you seen other professionals about these problems? If so, list names and approximate dates (include hospitalizations).

_____

Trauma History

	Current	Ever		Current	Ever
Traumatic accident	☐	☐	Verbal/emotional abuse	☐	☐
Physical abuse	☐	☐	Sexual abuse	☐	☐

Comments (specify circumstances, time frame and abuser) _____

_____

Safety

	Current	Ever
Feelings or thoughts that you don't want to live	☐	☐
Thoughts of harming or killing someone else	☐	☐

If so, when was the last time you had these thoughts _____

How often do you have these thoughts/feelings _____

Have you ever thought about how you would kill yourself or harm others, if so, describe _____

What keeps you from acting on these thoughts/feelings _____

Have you tried to kill yourself or harm others before? _____

Do you know of or are related to anyone who has killed themselves? If so what was their relationship to you? _____

Do you have access to guns? If so, explain _____

Medical History

Primary Care Provider _____ Drug/Food Allergies _____

Have you seen a specialist? List names, approximate dates, and reason for consultation.

_____

Are there any current health concerns?

_____

Have you had any of the following?

☐ Asthma/breathing problems	☐ Headaches	☐ Stomach/Bowel problems	☐ Seizures
☐ Concussion/blows to head/knocked out	☐ Neurologic Problems	☐ Heart Problems	☐ Accidents
☐ Broken Bones	☐ Cancer	☐ Eyes/ears/nose/throat problems	☐

Please describe any checked or other health issues. _____

_____

Have you had any hospitalizations or surgeries? If so, identify reason and approximate dates. _____

_____

What type of exercise do you do? How often and for how long? _____

For women only: Date of last menstrual period _____ Are you currently pregnant or think you could be pregnant? _____

Are you planning to get pregnant in the near future? _____ No. of pregnancies _____ No. of live births _____ Birth Control Method _____

Substance Use:

Substance	Never Used	Past Use	Current Use	How Often	How much On average? At most?	Last use	Have you thought of cutting down?	Have others been critical or concerned of your use?
Caffeine soda,coffee,energy drink								
Tobacco Cigarette, pipe, chew								
Alcohol Beer, wine, liquor								
Marijuana Smoke/ ingest pot, weed								
Hallucinogens LSD, PCP, peyote								
Inhalants Paint, glue								
Opioids Narcotic pain killers, heroin, methodone								
Stimulants Speed, meth, cocaine								
Sedatives Sleeping pills, tranquilizers ,anxiety medication								
Club Drugs MDMA, roofies, ecstasy								
Steroids Gym candy, pumpers								

Have you used intravenous drugs? _____

Educational History

Highest grade completed? _____ Highest degree attained? _____ Where? _____

What were your typical grades like? _____ Ever suspended or expelled from school? _____

Have you ever been in any special education program? If so, what type and for how long? _____

Primary language _____ Other languages that you speak _____

(Continued on back side)

Family History

Please identify any known or suspected history of the following problems in your blood relatives. Indicate the relative and whether maternal or paternal (i.e. maternal aunt, paternal grandmother)

Anxiety, panic, worry _____ ADHD/attention problems _____

Depression _____ Mood disorder/bipolar/manic depression _____

Suicide _____ Other _____

Schizophrenia _____ Eating problems/disorders _____

Alcohol problems _____ Drug problems _____

Learning Problem/developmental/intellectual problems _____

Behavior Problems _____ Court involvement _____

Diabetes _____ Heart problems _____

Thyroid Condition _____ Seizures/migraines _____

List the names, ages, and occupations/grades of family members, others living in the house hold, or other caretakers

Name	Age	Relationship	Quality of relationship Good, distant, problematic	School or Job (if employed)	Living in household
					☐ Yes/No ☐
					☐ Yes/No ☐
					☐ Yes/No ☐
					☐ Yes/No ☐
					☐ Yes/No ☐
					☐ Yes/No ☐
					☐ Yes/No ☐

Social History

Are there any particular stressors or recent changes in the family such as job changes, legal problems, financial problems, school changes, health problems, marriage, separation or divorce, violence or substance abuse? If so explain.

_____

_____

Have there ever been problems with the law, financial problems, serious health problems, separations/divorces, violence, substance abuse, problematic moves or job changes that occurred in your family? If so, explain

_____

_____

_____

Occupational History

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

What is/was your type of work/occupation? _____ How long in the present position? _____

Have you ever served in the military? _____ If so, what branch and when? _____

What type of discharge? ☐ Honorable ☐ Other type discharge, specify _____

Other

Do you make friends easily? ☐ Yes ☐ No If no, please explain._____

Who provides the most emotional support to you? _____

What do you do for fun or enjoyment? _____

What is your religious background? _____ How important is this to you? _____

How many times have you been married and how long did each marriage last? _____

Are there any other significant other(s) in your life? If so, explain. _____

What do you or others consider as your strengths? _____

Anything else you think would be important for your provider to know? _____

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