Assessment Questionnaire — Adult Individual

(Parents, please fill out on behalf of your child or with your child)

Cottonwood Creek Counseling
Individual, Couple, & Family Therapy

Client Name:_____ **Date of Birth: _____ Gender: _____**

***Current Symptoms Checklist** (check once for any symptoms present, twice for major symptoms)**:**

(_) Depressed mood	(_) Racing thoughts	(_) Excessive worry
(_) Unable to enjoy activities	(_) Impulsivity	(_) Anxiety
(_) Changes in sleep: increase/decrease	(_) Increase in risky behavior	(_) Panic attacks
(_) Loss of interest	(_) Change in desire/motivation	(_) Hallucinations: visual/audio
(_) Difficulty with concentration	(_) Forgetfulness	(_) Suspiciousness or paranoia
(_) Change in appetite: increase/decrease	(_) Excessive energy	(_) Avoidance/Isolation
(_) Excessive guilt or shame	(_) Increased irritability	(_) _____
(_) Fatigue	(_) Crying spells	(_) _____
(_) Mood swings	(_) Obsessions	(_) _____

***Presenting Problem** (What are you seeking help for? Describe physical and emotional symptoms—onset, intensity, frequency. When did challenges begin?):

***Major Life Events in the Past Year** (moves, job changes, deaths, births, illnesses, accidents, injuries, etc.):

***Past History of Therapeutic Treatment** (type, presenting problem, when, duration, effectiveness, why discontinued):

***Attempts to Resolve Presenting Problem** (techniques/resources, duration, effectiveness):

Cottonwood Creek Counseling – 7321 S. State St. Ste. A, Midvale, Utah, 84047 – (801) 878-4327

***Risk Factors** (Present or history of any thoughts, feelings, or actions regarding: suicide, self-harm, homicide, eating disorder, domestic violence?):

***Spirituality** (Do you identify with a specific religion or belief system, interact with clergy/bishop, attend meetings, comfort level using in therapy?):

***Strengths and Support System** (describe friends and family support, your personal strengths, desire and commitment to make changes):

***Challenges** (what will be difficult for you in making desired change? Impatient, stubborn, disabilities, lack of support, etc.):

***Relationship Status** (single/dating/married/separated/divorced/widowed, length of relationship, satisfaction, previous relationships):

***Individuals living in the home** (name, relation, age):

***Other immediate family members not living in the home** (name, relation, age):

***Employment** (company, position, number of hours per week, length of time with company/position, satisfaction, difficulties):

***Education** (grade, school, likes/dislikes, learning disabilities, strengths, weaknesses):

***Mental Health History** (personal and family history of: depression, anxiety, OCD, bipolar, schizophrenia, psychiatric hospitalization; diagnoses received):

***Current Medications** (name, purpose, dosage, effectiveness, side effects, start date, date of last adjustment, doctor prescribing medication):

***Medical History** (personal: surgeries, major illnesses, chronic pain, formal diagnoses; family history):

***For Women Only:** Any difficulties with menstruation: _____

Are you currently pregnant or do you think you might be pregnant? ◯ Yes ◯ No

Are you planning to get pregnant in the near future? ◯ Yes ◯ No

Birth control method _____ (if applicable)

How many times have you been pregnant? _____ How many live births? _____

***Alcohol and Substance Use** (alcohol, cigarettes, tobacco, chew, recreational substances, others [indicate present or past and frequency]):

***Dependence/Addiction History** (present and past: drug and alcohol, caffeine, sexual, pornography, gaming, social media, spending, gambling):

***History of Abuse** (physical, sexual, rape, trauma: when, how long did it continue, was a report made, current safety measures if necessary):

***Goals you desire to accomplish through therapy**:

***Additional Information (use back of page if needed)**

Person filling out form: _____ _____ _____

Print Signature Date