



**Coastal Haven Counseling, LLC**  
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### Adult Initial Clinical Assessment

Client Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Parent/Legal Guardian (if under 18): \_\_\_\_\_

Address: \_\_\_\_\_

Cell/Other Phone: \_\_\_\_\_ May we text or leave a message? Yes  No

Email: \_\_\_\_\_ May we leave a message? Yes  No

\*Email or texting correspondence is not considered to be a confidential medium of communication.

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital Status: Never Married  Married  Separated  Divorced  Widowed  Dom Partner

Referred By (if any): \_\_\_\_\_

Reason you are seeking treatment: \_\_\_\_\_

\_\_\_\_\_

Areas of your life it is affecting: \_\_\_\_\_

Household members, age and relationship: \_\_\_\_\_

\_\_\_\_\_

Suicidal risk? [ ] Denies [ ] Ideas [ ] Plans [ ] Hx of attempts [ ] Hx in family

Homicidal risk? [ ] Denies [ ] Ideas [ ] Plans [ ] Hx of attempts [ ] Hx in family

Self-Mutilation? [ ] Denies [ ] Ideas [ ] Plans [ ] Hx of attempts [ ] Hx in family

Other risk behaviors: [ ] Denies [ ] Unprotected sex [ ] Gang affiliations [ ] Violence [ ] Fire setting

Have you had any issues with shoplifting? \_\_\_\_\_

\_\_\_\_\_

**History:** Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Yes  No  previous therapist/practitioner: \_\_\_\_\_

What was your diagnosis: \_\_\_\_\_

Did your previous treatment help? Yes  No  What did you learn from your previous treatment? \_\_\_\_\_

When and where was your previous treatment? Inpatient or outpatient? \_\_\_\_\_

**General and Mental Health Information:**

1. How would you rate your current physical health? Poor  Satisfactory  Good Very

Please list any specific health problems you are currently experiencing: \_\_\_\_\_

2. How would you rate your current sleeping habits? Poor  Satisfactory  Good Very

Please list any specific sleep problems you are currently experiencing: None  \_\_\_\_\_

3. What types of exercise do you participate in and how frequently? \_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating problems:

None  \_\_\_\_\_

5. Are you currently experiencing overwhelming sadness, grief or depression? Yes  No

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panics attacks or have any phobias?

Yes  No  If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain? Yes  No

If yes, please describe: \_\_\_\_\_

8. How many times per week do you drink alcohol? \_\_\_\_\_ When you do drink, what type of beverage do you drink, and how much? \_\_\_\_\_

9. How often do you engage in recreational drug use? Daily  Weekly  Monthly  Never

10. Are you currently in a romantic relationship? No  Yes  If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

11. What are the biggest challenges you have with your personal relationship? \_\_\_\_\_

12. What significant life changes or stressful events have you experienced recently? \_\_\_\_\_

13. Who is your primary care physician (name, phone and address): \_\_\_\_\_

Has client ever had problems with:

Seizure/epilepsy	Y N _____	Drug Abuse	Y N _____
Diabetes	Y N _____	Heart Problems	Y N _____
Lung Disease	Y N _____	Thyroid Disease	Y N _____
Tuberculosis	Y N _____	Kidney Disease	Y N _____
High Blood Pressure	Y N _____	Anemia	Y N _____
Hepatitis	Y N _____	Trouble with seeing	Y N _____
STDs	Y N _____	Trouble Hearing	Y N _____
Head Injury	Y N _____	Chronic Pain	Y N _____
Alcohol Abuse	Y N _____	Asthma	Y N _____

Medical Hospitalizations client has had in the past? (Surgeries, Illness, accidents, etc.)

Reason	Date
_____	_____
_____	_____
_____	_____

Current Medications (Including prescription, over the counter or herbal medicines)

Name of Medicine	Dose	Given for
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to food, medications or other things? [ ] Y [ ] N \_\_\_\_\_

**Family Mental Health History:** In the section below identify if there is a family history **or if you have any issues** with any of the following. If yes, please indicate the family member's relationship to you (father, maternal grandmother, paternal uncle, etc.).

Alcohol/Substance Abuse: yes/no \_\_\_\_\_

Anxiety: yes/no \_\_\_\_\_

Depression: yes/no \_\_\_\_\_

Bipolar Disorder: yes / no \_\_\_\_\_

Domestic Violence: yes/no \_\_\_\_\_

Eating Disorders: yes/no \_\_\_\_\_

Obesity: yes/no \_\_\_\_\_

Obsessive Compulsive Behavior: yes/no \_\_\_\_\_

Schizophrenia: yes/no \_\_\_\_\_

Suicide Attempts: yes/no \_\_\_\_\_

Homicide or Attempts: yes / no \_\_\_\_\_

Sexual Abuse of client or other family members yes/no \_\_\_\_\_

**Please check all of the behaviors and symptoms that you consider a problem:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Distractibility              | <input type="checkbox"/> Change in appetite        | <input type="checkbox"/> Excessive energy                        |
| <input type="checkbox"/> Hyperactivity                | <input type="checkbox"/> Lack of motivation        | <input type="checkbox"/> Mood swings                             |
| <input type="checkbox"/> Impulsivity                  | <input type="checkbox"/> Withdrawal from<br>people | <input type="checkbox"/> Sleep problems                          |
| <input type="checkbox"/> Boredom                      | <input type="checkbox"/> Anxiety/worry             | <input type="checkbox"/> Nightmares                              |
| <input type="checkbox"/> Poor memory                  | <input type="checkbox"/> Panic attacks             | <input type="checkbox"/> Eating problems                         |
| <input type="checkbox"/> Confusion                    | <input type="checkbox"/> Specific fears            | <input type="checkbox"/> Gambling problems                       |
| <input type="checkbox"/> Seasonal mood  <br>changes   | <input type="checkbox"/> Social discomfort         | <input type="checkbox"/> Computer addiction                      |
| <input type="checkbox"/> Sadness/depression           | <input type="checkbox"/> Obsessive thoughts        | <input type="checkbox"/> Pornography problems                    |
| <input type="checkbox"/> Loss of<br>pleasure/interest | <input type="checkbox"/> Compulsive behavior       | <input type="checkbox"/> Parenting problems                      |
| <input type="checkbox"/> Hopelessness                 | <input type="checkbox"/> Aggression/fights         | <input type="checkbox"/> Sexual problems                         |
| <input type="checkbox"/> Thoughts of death            | <input type="checkbox"/> Frequent arguments        | <input type="checkbox"/> Relationship problems                   |
| <input type="checkbox"/> Self-harm                    | <input type="checkbox"/> Irritability/anger        | <input type="checkbox"/> Work/school problems                    |
| <input type="checkbox"/> Crying spells                | <input type="checkbox"/> Homicidal thoughts        | <input type="checkbox"/> Alcohol/drug use                        |
| <input type="checkbox"/> Loneliness                   | <input type="checkbox"/> Flashbacks                | <input type="checkbox"/> Recurring bad<br>memories or nightmares |
| <input type="checkbox"/> Low self-worth               | <input type="checkbox"/> Hearing voices            |  |
| <input type="checkbox"/> Guilt/shame                  | <input type="checkbox"/> Visual hallucinations     |  |
| <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Suspicion of others       |  |
|   | <input type="checkbox"/> Racing thoughts           |  |

**Additional Information:**

1. Are you currently employed? \_\_\_\_\_ If yes, employer? \_\_\_\_\_

Is there anything stressful about your current work? \_\_\_\_\_

2. Describe your spiritual faith or belief (if any): \_\_\_\_\_

3. Where were you born and raised? \_\_\_\_\_

4. Describe the family who raised you: (how many siblings, quality of relationships):

\_\_\_\_\_

\_\_\_\_\_

5. Describe current family relationships: (significant other? children? quality of relationships?):

\_\_\_\_\_

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6. Describe past significant relationships (marriages, divorces, separations, etc.):

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7. Describe any significant losses/separations of any family members/significant others (including loss of pets, physical functions, property/possessions, etc.):

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8. Describe current housing situation (house, mobile home, boarding homes, shelter, homeless, etc.): Any needs? \_\_\_\_\_

9. Any problems/issues/changes with sex/sexuality?

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10. Describe current social involvement (activities that you enjoy with others):

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11. Describe educational background (how far in school, tech school, college, special ed., special programs, highest level completed):

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12. History of legal involvements, as well as any current legal problems:

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13. Have you experienced any past traumas? (sexual, accidents, domestic violence, ...)

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14. What would you like to accomplish out of your time in therapy?

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15. How will you or your life be different when you are ready for discharge from therapy? Complete this sentence...

*I will be ready for discharge when...* \_\_\_\_\_

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**Strengths, Needs, Abilities and Preferences:**

**Strengths:** (Family, social, spiritual & hobbies that have helped overcome past crises):

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**Needs:** (Client's expression of current needs: emotional, physical & environmental):

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**Abilities:** Client's ability to follow up with treatment: Yes/No

Client understands instructions & is willing to participate in treatment: Yes/No

**Preferences:** Appointment day/evening (circle).

**Are you currently seeking treatment from another provider:** Yes/No

**OFFICE USE ONLY:**

MENTAL STATUS				
<i>Affect</i>	• Appropriate	• Blunted	• Constricted	• Flat • Labile
<i>Appearance</i>	• Well-groomed	• Disheveled	• Inappropriate	
<i>Attitude</i>	• Cooperative	• Guarded	• Uncooperative	
<i>Mood</i>	• Euthymic	• Depressed	• Anxious	• Euphoric
<i>Motor Activity</i>	• Calm	• Hyperactive	• Agitated	• Tremors/Tics
<i>Thought Process</i>	• Intact	• Circumstantial	• Tangential	• Loose assoc.
<i>Thought Content</i>	• Appropriate	• Hallucinations	• Delusions	
<i>Orientation</i>	• Fully oriented	Disoriented as to: • Time • Place • Person		

Diagnosis:

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Criteria for Diagnosis:

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Therapist Name: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Intake Date: \_\_\_\_\_