



Coastal Haven Counseling, LLC
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 (843) 945-0346

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 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 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 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 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?):

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

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

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

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

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

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

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

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

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

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... _____

Strengths, Needs, Abilities and Preferences:**Strengths:** (Family, social, spiritual & hobbies that have helped overcome past crises):**Needs:** (Client's expression of current needs: emotional, physical & environmental):**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:Criteria for Diagnosis: Check all that apply:

ICA Info _____ Cross Cutter _____ PCP/Psychiatrist _____ Other Assessment Tool _____

Therapist Name: _____

Therapist Signature: _____ Intake Date: _____