Coastal Haven Counseling, LLC
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Adult Initial Clinical Assessment

Client Name:_____**Appointment Date:** _____

Parent/Legal Guardian (if under 18): _____

Insurance Number: _____

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: _____

Have you been seen within the last 6 months?: Yes □ No □

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, panic 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:

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

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…

_____

_____

_____

_____

SNAP:

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).

OFFICE USE ONLY:

Therapy recommended: Check all that apply: ____ Individual ____ Family

Frequency Check: ___ Weekly ___ Twice a Week ___ Other _____

MENTAL STATUS				
Affect	• Appropriate	• Blunted	• Constricted	• Flat • Labile
Appearance	• Well-groomed	• Disheveled	• Inappropriate	
Attitude	• Cooperative	• Guarded	• Uncooperative	
Mood	• Euthymic	• Depressed	• Anxious	• Euphoric
Motor Activity	• Calm	• Hyperactive	• Agitated	• Tremors/Tics
Thought Process	• Intact	• Circumstantial	• Tangential	• Loose assoc.
Thought Content	• Appropriate	• Hallucinations	• Delusions	
Orientation	• 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 _____

By signing these documents, therapist has deemed that the recommended services are medically necessary to restore functioning related to:
□ Home □ School □ Work □ Cognitive Functioning □ Social/Interpersonal Functioning,
Caused by mental health diagnosis.

Therapist Name: _____

Therapist Signature: _____ Intake Date: _____