Initial Assessment
Adult Relationship Issues

Today's Date: _____

Last Name, **First Name** **M.I.** **Age**

Street Address City State Zip

( ) ( )

Home Phone Number Work Phone Number

Name of Spouse/Significant Other

How did you hear of this counselor? _____

FAMILY/DEVELOPMENT INFORMATION

Information regarding Parents:

			Living		Living with you	
	NAME	**AGE**	**YES**	**NO**	**YES**	**NO**
Mother						
Father						

☐ Parents legally married
☐ Parents ever separated
☐ Parents divorced. If yes, how long? _____

☐ Mother remarried: Number of times ____
☐ Father remarried: Number of times ____

Information regarding Children: (use back of page if necessary)
Answering options for "Whose Child *" section below:

B Both of ours, natural child
BA Both of ours, adopted (or taken on)
M My natural child
MA My child, adopted (or taken on)
S Spouse's natural child
SA Spouse's child, adopted (or taken on)

Child's Name	**Age**	**Sex**	**Whose Child ***	**Living**		**Living w/ you**	
				Yes	**No**	**Yes**	**No**

Information regarding Significant Others (Brothers, Sisters, Grandparents, Step-relatives, Half-relative):

Relationship	**Name**	**Age**	**Living**		**Living w/ you**	
			Yes	**No**	**Yes**	**No**

Relational Status:

☐ Single

☐ Unmarried: living with significant other
Length of time _____

☐ Engaged: Wedding Date: _____

☐ Legally married. Length of time: _____
Is this your first marriage ☐ Yes ☐ No
If no, how many times have you been married? _____

☐ Separated
Length of Time: _____
How many times have you & your spouse separated: _____

☐ Annulment: Length of time: _____

☐ Divorce in progess

☐ Divorced: Length of time: _____

☐ Widowed: Length of time: _____

Assessment of Current Significant Relationship (if applicable): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please write a paragraph describing your life growing up.

_____

_____

_____

_____

_____

SOCIAL INFORMATION

Describe how you relate to people (e.g. easily, shy, leader, follower, extrovert, etc…).

_____

_____

Who do you socialize with (immediately family, extended family, friends, co-workers, etc…)?

_____

Who is your main source of emotional support (Family, friend, co-worker, no one, etc.)? _____

Do you isolate yourself from other people? ☐ Yes ☐ No
Explain: _____

Describe special interest or hobbies you may have (e.g. art, music, crafts, outdoor activity, church activity, books/films, physical fitness, diet/health, sports, etc.): _____

_____

Has your activity level changed recently? ☐ Yes ☐ No
If Yes, please explain: _____

Sexual Orientation (heterosexual, homosexual, bisexual): _____

List any sexual problems, concerns or difficulties you may be experiencing: _____

_____

SPIRITUAL/RELIGIOUS INFORMATION

Do you consider yourself a spiritual person? ☐ Yes ☐ No

What religion were you raised? _____

Do you practice a formal religion now? ☐ Yes ☐ No If yes, what religion? _____

LEGAL INFORMATION

Is there any information about legal situations I should know, including custody cases? ☐ Yes ☐ No
If Yes, please describe: _____

EDUCATION INFORMATION

Briefly describe your educational training (e.g. level of completion, diplomas, degrees, etc.) _____

_____

EMPLOYMENT/VOCATIONAL INFORMATION

Are you employed? ☐ Yes ☐ No If Yes, who is your employer and briefly describe your work: _____

_____

Special circumstance(s) (e.g. laid off, self-employed, suspended, disabled, retired, social security, etc.):

_____

Is your significant other employed? ☐ Yes ☐ No If Yes, please state their occupation: _____

PHYSICAL HEALTH INFORMATION

Do you have any health concerns I should know about? ☐ Yes ☐ No
If Yes, please describe: _____

Are you taking any medications? ☐ Yes ☐ No
If Yes, what medications and please describe for what purpose: _____

_____

Any recent changes in:

Sleep patterns	☐ Yes	☐ No	Physical activity level	☐ Yes	☐ No
Eating patterns	☐ Yes	☐ No	General disposition	☐ Yes	☐ No
Behavior	☐ Yes	☐ No	Weight	☐ Yes	☐ No
Energy Level	☐ Yes	☐ No	Increase in nervousness or tension	☐ Yes	☐ No

If you answered yes to any of the above, please explain: _____

_____

_____

Do *you* use drugs or substances of any kind? ☐ Yes ☐ No If yes, please describe: _____

Does your *significant other* use drugs or substances of any kind? ☐ Yes ☐ No
If yes, please describe: _____

Do you drink alcohol? ☐ Yes ☐ No
If Yes, is your level of drinking: ☐ Occassional ☐ Moderate ☐ Heavy ☐ Binging
Please describe your usage: _____

COUNSELING/PRIOR TREATMENT INFORMATION

Have you had previous counseling experience? ☐ Yes ☐ No
If Yes, please describe: _____

What was the outcome? _____

CLIENT SIGNATURE: _____ DATE: _____