ADULT PRE-ASSESSMENT

18+ ONLY

Date: _______________

Crossroads

Christian Professional Counseling for Individuals and Families

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Name: ____ Age: _______________ Gender: M or F

Please briefly describe why you are here:

____

____

If you had to describe major symptoms for which you are seeking therapy, they would be:

- ❑ Depression
- ❑ Anxiety
- ❑ General Sadness
- ❑ Mood Swings
- ❑ Obsessive Worries
- ❑ Panic Anxiety
- ❑ Times of Confusion
- ❑ Anger
- ❑ Change in Appetite
- ❑ Loss of Memory
- ❑ Drug Abuse
- ❑ Inattention/Hyperactivity
- ❑ Behavioral Problems
- ❑ Grief
- ❑ Self Esteem Issues
- ❑ Other: ______________

Please check the major stressor(s) that preceded or accompanied your symptoms:

- ❑ Parent's Marital Issues
- ❑ Parent/Child Issues
- ❑ School Issues
- ❑ Health Issues
- ❑ Trauma
- ❑ Bullying
- ❑ Adjustment to Divorce
- ❑ Significant Change in Family Situation
- ❑ Loss of Significant Person in Child's Life
- ❑ New Addition to the Family (Birth, Adoption, or other)
- ❑ Adoption Issues
- ❑ Relationship or Family Issues
- ❑ Blended Family Issues
- ❑ Other: __________________

The symptoms began ______ (weeks / months) ago and have been (increasing) (decreasing) (no change)

My three biggest concerns in life at the present time are:

1. ____
2. ____
3. ____

Please state your goals for therapy:

1. ____
2. ____
3. ____

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Please check all of the following that you have experienced and how often:

Some	Weekly	Daily	
◯	◯	◯	Increased Crying
◯	◯	◯	Poor Concentration
◯	◯	◯	Change in Sleep Pattern
◯	◯	◯	Appetite Changes
◯	◯	◯	Weight Changes
◯	◯	◯	Lack of Interest in usual activities
◯	◯	◯	Decreased Self-Esteem
◯	◯	◯	Hopelessness/Helpless Feeling
◯	◯	◯	Being Withdrawn
◯	◯	◯	Nightmares
◯	◯	◯	Rapid Heartbeat
◯	◯	◯	Increased Sweating
◯	◯	◯	Shortness of Breath
◯	◯	◯	General Anxiety
◯	◯	◯	Chest Discomfort
◯	◯	◯	Feeling Dizzy
◯	◯	◯	Chills or Hot Flashes (Circle which one)
◯	◯	◯	Outburst of Anger
◯	◯	◯	Restlessness, keyed up, irritability, muscle tension, decreased sleep (Circle which one)
◯	◯	◯	Stomach Issues
◯	◯	◯	Startled Response
◯	◯	◯	Feeling 'High" with racing thoughts, increases speech, decreased sleep, and increased activity or energy level
◯	◯	◯	Preoccupation w/ Particular things or people. List: ______________________________
◯	◯	◯	Hyper Vigilance Excessive attention and focus on things or people
◯	◯	◯	Inattention
◯	◯	◯	Hyperactivity
◯	◯	◯	Impulsiveness
◯	◯	◯	Excessive Fears
◯	◯	◯	Obsessions/Compulsions - constant checking, washing, or counting type behaviors; unrelenting worries
◯	◯	◯	Hallucinations (hearing voices/music that no one else hears)
◯	◯	◯	Avoidance of anything associated with a trauma experienced
◯	◯	◯	Post Traumatic Stress experiences. List: ______________________________
◯	◯	◯	Fear or Anxiety of any places or inescapable situation
◯	◯	◯	Social Phobia (persistent fear of social or performance situation where embarrassment may occur)
◯	◯	◯	Specific Phobia (persistent fear of certain objects or situations) List: ____________________
◯	◯	◯	Isolating Self from all contact with others
◯	◯	◯	Amnesia
◯	◯	◯	Running Away
◯	◯	◯	Truancy
◯	◯	◯	Memory impairment with trouble organizing thoughts
◯	◯	◯	Undue health worries with no adequate explanation
◯	◯	◯	Agitated-irritable (easily annoyed and provoked to anger)
◯	◯	◯	Suspiciousness
◯	◯	◯	Delusions/Paranoia. Explain: ____________________________________

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Please check all of the following that you have ever experienced:

◯Behavioral Problems. Explain: ____
◯Self Mutilation (cutting, etc.) Last occurrence: _______________
◯Eating Issues (under or over eating, binging, or purging) Specify: __________________
◯Sexual Issues (addiction, performance anxiety, pornography)
◯Serious Health Issues. Explain: ____
◯Legal Issues
◯Severe Trauma
◯Suicidal Thoughts. If yes, last occurrence: _____________________ Describe the situtaion and nature of the thoughts:____
◯Suicide Attempts. If yes, when and how: ____

Medical History

Please list any **psychiatric** medications you are currently taking:

Medication Date Began Side Effects

1. ____
2. ____
3. ____
4. ____

Have you ever been diagnosed with a psychiatric or mental disorder? YES NO
If yes, Please describe diagnosis: _____________________________________ Diagnosed by Whom? _______________

Have you been to counseling before? YES NO When? _________ Where? __________________________
Reason? ____

Have you ever been hospitalized for a psychiatric disorder? YES NO
Please Explain:

____
____
____

Please describe any current medical conditions you may have: (diabetes, asthma, etc.)

____
____

Do you suffer from Chronic Pain? YES NO
Please describe:

____
____

Please list any supplements or vitamins you take:

____
____

Please list any ***Non*-psychiatric** medications you are currently taking:

Medication	Date Began	Side Effects

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Family History

Describe Relationship with Father:

____
____
____

Describe Relationship with Mother:

____
____
____

Describe Relationship with siblings: (how many, where you are in birth order, your 'role')

____
____
____

In general, you would describe your childhood and family of origin as:

- ❑ Pleasant
- ❑ Great
- ❑ Normal amount of fussing but generally good
- ❑ Abusive
- ❑ I have very little memory of my childhood
- ❑ I am mostly withdrawn from my family
- ❑ Dysfunctional
- ❑ Other: __________

Description of Current Family

Married? YES NO How many years? __________ Divorced? YES NO How many years? __________

I presently live with:

- ❑ Spouse
- ❑ Alone
- ❑ Parents
- ❑ Other: __________

My sexual orientation is:

- ❑ Heterosexual
- ❑ Homosexual
- ❑ Other: __________

My current support system (including family and friends) is:

- ❑ Good
- ❑ Fair
- ❑ Poor

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Please describe any current stress in your family/marriage?

____

____

____

Do you have Children? Yes No If so, How many?______________ Have you ever had an abortion? Yes No

Have you ever had a miscarriage? Yes No Do you suffer from infertility? Yes No I don't know

Drug/Alcohol History

Do you smoke cigarettes?	Yes	No
Do you have a desire to stop or reduce smoking?	Yes	No
Do you currently use drugs or alcohol?	Yes	No
If so, do you feel pressured by others to reduce the use of drugs and alcohol?	Yes	No
Do you often feel a sense of guilt and desire top reduce the use of drugs or alcohol?	Yes	No

If you use alcohol, please describe how often and for how many years you have used it:

____

____

____

If you have EVER used illegal drugs, please list what drugs you have used, how often, and for how many years?

____

____

____

Religious Beliefs

Do you consider yourself religious/spiritual?

- ❑ Yes
- ❑ No
- ❑ Somewhat
- ❑ In the Past

Is so, What denomination/religion do you practice? ____

Is this the same as your family of origin? Yes No

Do you attend church?

- ❑ Never
- ❑ Rarely
- ❑ Occasionally
- ❑ Once a month
- ❑ Nearly every week or more

School/Career

What level of school did you complete?

- ❑ Middle School
- ❑ High School
- ❑ GED or Equivalent
- ❑ College

- ❏ Graduate or Professional Degree
- ❏ Other: ________________
- ❏ Currently in School (Level: ________________)

Are you currently employed? Yes No
Are you satisfied in your job? Yes No Somewhat

Please describe any issues you may be having with your job/career or school:

____
____
____

Please use the space below to add any information that was not covered or mentioned that you feel is important for the therapist to know in regards to your therapy:

____
____
____
____
____