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**New Hope Counseling (470) 253-1933**

## Adult Self Report Form

***This form is completely confidential***

**Today's date: _____**

**Your name: _____Date of birth_____**

**Age _____ Race _____**

***The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.***

**Please briefly describe your presenting concern(s) & what you would like to see changed:**

_____

_____

_____

_____

**Please check the behaviors and symptoms that occur to you more often than you would like them to take place:**

| | | |
|---|---|---|
| ___Aggression | ___Elevated mood | ___Phobias/fears |
| ___Alcohol dependence | ___Fatigue | ___Recurring thoughts |
| ___Anger | ___Gambling | ___Sexual addiction |
| ___Antisocial behavior | ___Hallucinations | ___Sexual difficulties |
| ___Anxiety | ___Heart palpitations | ___Sick often |
| ___Avoiding people | ___High blood pressure | ___Sleeping problems |
| ___Chest pain | ___Hopelessness | ___Speech problems |
| ___Cyber addiction | ___Impulsivity | ___Suicidal thoughts |
| ___Depression | ___Irritability | ___Thoughts disorganized |
| ___Disorientation | ___Judgment errors | ___Trembling |
| ___Distractibility | ___Loneliness | ___Withdrawing |
| ___Dizziness | ___Memory impairment | ___Worrying |
| ___Drug dependence | ___Mood changes | ___Sleeping too much |
| ___Eating disorder | ___ Headaches | ___ Feeling Manic |
| ___Panic attacks | ___ Nausea | ___Abdominal Distress |
| ___Fainting | ___ Sweating | ___Shortness of Breath |
| ___Blackouts | ___ Chills/Hot flashes | ___Severe Weight Gain/Loss |
| ___Nightmares | ___ Short Attention span | ___Pain in joints |
| ___Fidgeting | ___ Difficulty with Finances | ___Difficulty with Relationships |
| ___Hyperactivity | ___ Repetitive Behaviors | ___Muscle tension |
| ___Flashbacks | ___ Difficulty trusting others | ___Other_____ |

Briefly discuss how the above symptoms impair your ability to function effectively:

_____

_____

- Are you currently having thoughts of harming yourself or someone else? Yes No
- Have you had thoughts/ intents in the past of harming yourself or someone else? Yes No

## PAST TREATMENT

1. Have you ever participated in therapy for psychiatric, substance abuse, emotional, or behavioral problems in the past? Y N

If yes, when, where, and with whom? _____

Reason for termination _____

2. Did you find past treatment helpful? Y N Why or why not?_____

## MEDICAL HISTORY:

3. Please explain any significant medical problems, symptoms, or illnesses

_____

4. Current Medication Name, Dosage, & Purpose _____
5. When was the last time you were seen by a doctor? _____
6. Do you have any trouble sleeping?

## SUBSTANCE ABUSE

7. Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex, etc.)? Y N
8. Do you currently attend support groups? YES NO If yes, please list: _____
9. Do you drink alcohol? YES NO. How often? _____
10. Circle the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants.
11. Have you experienced withdrawal symptoms? YES NO If yes, circle all which apply: withdrawal, headaches, nausea, vomiting, tremors, seeing things, hearing things, other
12. Have you ever had a DUI? YES NO Date (if YES) _____
13. Have any of your friends or family members voiced concern about your substance use? YES NO
14. Have you ever been in trouble or in risky situations because of your substance use? YES NO

## LEGAL ISSUES

15. Do you have any current legal issues? YES NO If yes, please describe:

_____

16. Are you currently on probation/parole? YES NO
17. Do you have a DFACS worker? YES NO

## RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

**Marital Status (Circle all that apply)**

Single Divorce in process Unmarried, living together

Married Separated Divorced Widowed

Total number of marriages:

Total years of current status:

Assessment of current relationship (if applicable): Good Fair Poor

Current level of satisfaction with your friends and social support: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

18. Please briefly describe your coping mechanisms

_____

19. How would you describe your social life?

_____

20. How would you describe your diet and exercise patterns? (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

## FAMILY

Who Lives in the Same Residence as You? Please list their Name, Relationship, Age, & Occupation below:

## FAMILY HISTORY

Father _____ Age_____ Living or Deceased _____ Occupation_____
Mother _____ Age_____ Living or Deceased _____ Occupation_____
Siblings_____ Age_____ Living or Deceased _____ Occupation_____
Siblings_____ Age_____ Living or Deceased _____ Occupation_____
Siblings_____ Age_____ Living or Deceased _____ Occupation_____
Any significant family not mentioned above:

**FAMILY HISTORY OF (Circle all that apply):**

Drug/Alcohol Problems Physical Abuse Depression
Legal Trouble Sexual Abuse Anxiety
Domestic Violence Hyperactivity Psychiatric Hospitalization
Suicide Learning Disabilities "Nervous Breakdown"

21. Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

22. How would you describe your relationship with your mother? _____
_____

23. How would you describe your relationship with your father? _____
_____

24. How would you describe your relationships with your siblings?
_____

25. Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life:
_____

## EDUCATION & CAREER

26. High School/GED___ College Degree___ Graduate Degree (or Higher) ___ Vocational Degree___

27. Did you experience difficulties in school? YES NO. If yes, please list:

_____

28. Circle current employment status:

full time, part time, unemployed, homemaker, student, disabled, retired

29. What is your current employment (if applicable)

_____

30. Employment Satisfaction: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

## RELIGIOUS CONCERNS

31. What is your present religious affiliation? _____

32. How important is religious commitment to you?

| Unimportant | | | Average importance | | | | Extremely important | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

33. Do you desire to have your religious beliefs & values incorporated into the counseling process?

____ Yes ____ No _____ Not Sure

If Yes, please explain: _____

_____

## OTHER AREAS OF CONCERN

34. Do you have any history of abuse, neglect and/or trauma? YES NO

35. What are your hobbies/interests? _____

36. Do you have any sexual orientation/gender issues or concerns? YES NO

37. Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ Transgender__ in Question__

38. Are you having difficulties with spiritual or religious matters? YES NO

39. Do you have difficulties or concerns about how you get along with other people? YES NO

40. Any additional information you would like to include:

_____

**Signature of Client (or person completing form)** _____

**Date**_____