Amy Grassi Watson, PC

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Preliminary Assessment

PERSONAL HISTORY

Date: _____________

Name: _____________________________________ Age: ____ Date of Birth: ______________

Gender: _____M ______F ____ Transgender Years of education: _______________

School/Place of Work: _____________________________ Occupation: _________________

Present Marital Status:

_______ Never married _______ Separated

_______ Engaged to be married _______ Divorced and not remarried

_______ Married _______ Widowed and not remarried

How many times have you been married? _________

Do you have children? ___ Yes ____ No ___ N/A

If yes, ages and sex of children:

____

____

Any custody issues? ___ Yes ___ No ___ N/A

If yes, you may be asked to provide legal custody documents for clinical file

.

Legal Guardian (if applicable)? ____

COUNSELING HISTORY

Have you received counseling in the past? _____ Yes _____ No

If yes, what was the name of the therapist and when was the last time you saw them?

____

Date and Duration of therapy? ______________________________

Presenting problem at that time? ____

____

Briefly share why you are seeking therapy now?

____

____

____

How long has this problem persisted? ____

SYMPTOMS

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

☐ Aggression
☐ Alcohol dependence
☐ Anger
☐ Antisocial behavior
☐ Anxiety
☐ Avoiding people
☐ Chest pain
☐ Depression
☐ Disorientation
☐ Distractibility
☐ Dizziness
☐ Drug dependence
☐ Eating disorder
☐ Elevated mood
☐ Fatigue
☐ Hallucinations
☐ Heart palpitations
☐ High blood pressure
☐ Hopelessness
☐ Impulsivity
☐ Irritability
☐ Judgment errors
☐ Loneliness
☐ Memory impairment
☐ Mood shifts
☐ Panic attacks
☐ Phobias/fears
☐ Recurring thoughts
☐ Sexual difficulties
☐ Sick often
☐ Sleeping problems
☐ Speech problems
☐ Suicidal thoughts
☐ Thoughts Disorganized
☐ Trembling
☐ Withdrawing
☐ Worrying
☐ Other (specify)

____
____
____
____

TRAUMA

Any history of trauma (Ex: physical abuse, sexual abuse, neglect, car accident, victim of a crime, etc.)

____
____
____
____

CURRENT MEDICATIONS:

Drug	Frequency	Amount	Effective?	Prescribing Dr.

FAMILY HISTORY

Natural Mother's History: age ________ occupation: ____
School: highest grade completed: _____________ Marriages: ____
Medical Problems: ____
____
Has mother ever sought psychiatric treatment? Yes ______ No _______ If yes, for what purpose? _______
____

Mother's alcohol/drug use history ____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify)

____

____

____

Natural Father's History: age _______ occupation: ____
School: highest grade completed: ____________ Marriages: _______________________________________
Medical Problems: ____

____

Has father ever sought psychiatric treatment? Yes _____ No ______ If yes, for what purpose? ___________

____

Father's alcohol/drug use history ____

____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify)

____

Siblings? If so, how many and what ages?

____

____

____

Please list any other important information about family history (i.e. step-parents, step-siblings, adoption, etc.)

____

____

____

SUBSTANCE ABUSE HISTORY: ☐N/A
These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

Drug	Frequency	Amount	As of 1st Use	Last Use

Substance Abuse treatment History? ____ Yes ____ No ___ N/AIf yes, what was the name of the therapist and when was the last time you saw them? Date and Duration of therapy? _______________________________

SEXUAL HISTORY:

☐Heterosexual ☐Homosexual ☐ Bisexual ☐Unsure ☐Other: _________________________

Age at the time of first sexual experience: ____________________

Any history of sexual transmitted disease? ____________________ History of abortion? ___________________

History of sexual abuse, molestation or rape? ____

Current sexual problems? ____

MEDICAL HISTORY

Name and address of your primary physician:

Physician's name: ____

Address: ____

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc):

____

____

____

Sleep patterns/number of hours of sleep each night? ____

Describe your appetite (during the past week):___ poor appetite____ average appetite ___ large appetite

SPIRITUAL /RELIGIOUS

What is your present religious affiliation, If any? ____

How important is religious commitment to you?

Unimportant			Average Importance			Very Important
1	2	3	4	5	6	7

Concerns in this area? ____

____

____

CULTURAL INFORMATION:

Please share information needed regarding cultural norms, beliefs, values, etc…

____

____

____

____

Other information that you believe would be helpful, please include here:

____

____

____

Name of who completed this form: _______________________________

Relationship: __ Self __Parent __ Other ____________________________

Signature: ____ Date: ______________________