Adult Self Report Form ***This form is completely confidential*** **Today's date: _____**

1924 Clairmont Rd Ste 200 ❖ Decatur, Georgia 30033 ❖ Phone: (678) 856-5031

Name: _____Date of birth: _____

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):

_____
_____
_____
_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place: List the onset and frequency of each checked behavior/symptom (i.e., 2 months ago, 3-4x wk)

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Panic attacks
___ Fainting
___ Blackouts
___ Nightmares
___ Fidgeting
___ Hyperactivity
___ Flashbacks
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood changes
___ Headaches
___Nausea
___ Sweating
___ Chills/Hot flashes
___ Short Attention span
___ Difficulty with Finances
___ Repetitive Behaviors
___ Difficulty trusting others
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Sleeping too much
___ Feeling Manic
___ Abdominal Distress
___ Shortness of Breath
___ Severe Weight Gain/Loss
___ Pain in joints
___ Difficulty with Relationships
___ Muscle tension
___ Other_____

Briefly discuss how the above symptoms have impaired your ability to function effectively as a couple:

_____
_____

1. Are you having thoughts of hurting yourself or someone else? YES NO

Substance Abuse

2. Have you ever been treated for drug, alcohol abuse, or other addictions (food, gambling, sex, etc)? Y N

3. FAMILY HISTORY OF (Check all that apply):

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

4. RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Marital Status (more than one answer may apply)

☐ Single ☐ Legally married, length of time: ____ ☐ Unmarried, living together, length of time:_____

☐ Separated, length of time: _____ ☐ Divorced, length of time:_____ ☐ Widowed, length of time:___

☐ Annulment, length of time: _____ ____Total number of marriages

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

5. Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

6. Please briefly describe your coping mechanisms and self-care:_____

7. Is spirituality important in your life and if so please explain: _____

EDUCATION & CAREER

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

9. Circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired

10. What is your current employment (if applicable)

_____

POOR EXCELLENT

OTHER AREAS OF CONCERN

11. Do you have any history of abuse, neglect and/or trauma? Yes No

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

13. What are your goals for therapy? What would you like to see changed?

_____

_____

Signature of Client (or person completing form) _____ Date_____