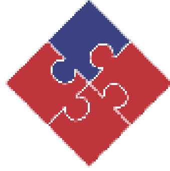

Corporate Care
GEORGIA

Adult Pre-Counseling Assessment

Contact Information

Today's Date ______________________________

Name: ______________________________

Date of Birth: ______________________________ Age: ______________________________

Address: ______________________________

____

Telephone:

Home: ____________________ Work: ____________________

Cell: ____________________ Other: ____________________

Contact in emergency: ______________________________ Phone: ______________________________

Marital Status

Single ________ Married _______ Divorced ______ Separated _____ Widowed _____

If married how long? ____________________ Spouse's name: ______________________________

If separated, divorced or widowed when did that happen? ______________________________

Previous marriages? ______________________________

Children's Names and Ages

____

____

____

____

____

Quality of Relationship

____

____

____

____

____

Education

Highest level of education completed: ______________________ Degree: ____________________________

Specialized training / trade school: ____

If you did not complete school, why not? ____

Do you have any learning or developmental disabilities? ____

Occupation

Where do you work and what is the nature of that work? ____

Do you find your work satisfying? ____

Family Background

Father – Name: ______________________________ Age: ______________

Living: ____ Deceased: ____

If Deceased, how and when? ____

Grade completed in school: _________ Occupation: ____

Quality of relationship:

Currently: __________________________ During childhood: __________________________________

Mother – Name: ______________________________ Age: ______________

Living: ____ Deceased: ____

If Deceased, how and when? ____

Grade completed in school: _________ Occupation: ____

Quality of relationship:

Currently: __________________________ During childhood: __________________________________

Parents were: married _____ divorced ____ never married _____

Relationship with stepparents if applicable: ____

Siblings' Names and Ages	Quality of Relationship
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Addiction history in family:

Father: ______________________

Mother: ______________________

Siblings: ______________________

Other: ______________________

None: ______________________

Psychiatric history in family:

Father: ______________________

Mother: ______________________

Siblings: ______________________

Other: ______________________

None: ______________________

Other noteworthy childhood relationships? ______________________

____

Other significant childhood events? ______________________

____

Spiritual Background

Do you regularly attend a church? Yes: ____ No: ____ Are you active? Yes: ____ No: ____

If attending, what is the name of the church? ______________________

How would you characterize your current relationship with God? ______________________

Current Situation

Briefly describe the problem that prompted you to seek counseling at this time: ____________________

____

Have there been times when the problem got better or disappeared? Yes: ____ No: ____

If yes, when? ____

What do you think helped? ____

____

Were there times when the problems were especially bad? Yes: ____ No: ____

If yes, when? ____

What made it bad? ____

____

Are there other people who play a major role in causing your problems or in helping you cope with your problems?

Yes: ____ No: ____ Explain briefly: ____

____

Is there anything else that you believe might be important for your counselor to know at this time? ____________

____

____

Drug/Alcohol History

Have you recently been using alcohol or other drugs? If so, describe: ____________________

____

Have you had any problem in the following areas related to your substance use? If so, describe:

Family: ____

Friends/Social: ____

Employment: ____

Financial: ____

Health: ____

Legal: ____

Self-esteem: ____

Other: ____

Describe your view of your substance use:

Not a problem _____

Becoming a problem _____

A severe problem _____

Have you ever attended:

12-step meetings _____

Treatment program _____

Addiction therapy _____

Longest period of sobriety and when: ____________________

How did you stay clean/sober? ____________________

Medical History

Describe any physical problems that require medication or physical care: ____________________

____

Are you currently receiving medical treatment? Yes: ____ No: ____

When did you last consult with your primary care physician? ____________________

Are you currently taking any prescription medications? Yes: ____ No: ____

If yes, please list by name and dosage: ____________________

____

Counseling History

Previous counseling/therapy? Yes: ____ No: ____ If yes, when? ____________________

With whom (name/address)? ____________________

____

What are the goals that you hope to reach through counseling? ____________________

____

____

____

____

____

Current Concerns

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate each item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Abused as a child
_____ Anger/Temper
_____ Aggression
_____ Bitterness
_____ Depression
_____ Difficulty in Communication
_____ Eating Difficulties
_____ Education
_____ Family Problems
_____ Fearfulness
_____ Financial Problems
_____ Grief/Loss
_____ Marital Problems
_____ Personality Conflicts
_____ Physical Problems
_____ Problems with Relationships
_____ Problems with Children

_____ Problems with Parents
_____ Resentment
_____ Spiritual Concerns
_____ Sexual Concerns
_____ Stress/Anxiety
_____ Thoughts of Suicide
_____ Trouble making Decisions
_____ Unhappy most of the Time
_____ Use of Alcohol by Self
_____ Use of Alcohol by Family Member
_____ Use of Drugs by Self
_____ Use of Drugs by Family Member
_____ Other Addiction
_____ Work
_____ Worry
_____ Other (specify): _______________
____

____
Signature

____
Date

____
Printed Name

PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is
2. I worry about
3. What I do best is
4. I have sometimes felt guilty about
5. What makes me angry is
6. My biggest mistakes were
7. My job
8. What makes we nervous is
9. My personality would be better if
10. I often felt that mother
11. Jesus Christ is
12. My temper
13. My childhood
14. Prayer is
15. My biggest disappointment
16. To me, sex is
17. I would be better liked if
18. I often felt that father
19. God to me is
20. My children (child) (brothers and sisters)
21. Women are
22. What hurts me most is
23. My biggest problem in life is
24. Men are