Patient Name_____

Adult
Initial Assessment

Identifying Information

Admission Date_____

Client Name:_____
DOB_____ Age____
Address_____
Phone #s_____

Primary Language_____ Secondary Language_____
Ethnicity_____
Occupation_____
Marital Status:_____

Referred By_____

Billing Information

Method of Payment:

Out of Pocket_____

Installments_____

Insurance_____
Group Number_____
Subscriber Name_____
Employer_____
Social Security Number_____

Copay per session_____
Note: **must** be paid at each session

Patient Name_____

Reason for Referral:
(current Sx, Onset, Course)

Client View of Problem: (stressors, precipitants)

Treatment Hx: (meds, therapy)

Hospitalizations

Daily Fx:

Patient Name_____

Emotional Fx:
Hx of trauma

Family fx:

Family Hx of Mental Illness
Roles/Relationships
Disciplinary Style
Conflict/Violence

Social Fx:

Educational Hx/Occupational Fx:

Patient Name_____

Medical Background:

Physician

_____ph#_____

Current conditions:

Tx/ Medications

History of illnesses/Injuries:

Patient Name_____

Mental Status /Behavioral Observations

Patient Name_____

Initial Diagnosis at Admission

AXIS I Principal:
Secondary:

AXIS II Principal:
Secondary:

AXIS III

AXIS IV

AXIS V Current GAF_____

Recommendations: