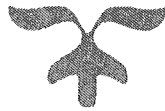




CONFIDENTIAL

NAME: _____



Adult Inventory

Adult Inventory

Please read and answer the following questions. Information provided will be discussed during your initial meeting with your therapist.

Presenting Information

What are your primary concerns?

When did these concerns first start? _____

How have you or your family members been trying to cope/manage with these concerns?

What changes, stresses, or losses have occurred in the past 1-2 years?

Mental/Emotional Health History

Have you ever received counseling of any type? Yes No

Have you had services with this agency prior to this date? Yes No

Have you been hospitalized for mental health or drug/alcohol treatment? Yes No

If yes, please explain and provide dates:

Past providers and dates of services:

Has anyone in the family been diagnosed with mental health or emotional illness? Yes No

If yes, explain:

Symptoms Checklist

Please rate each symptom below using the scale provided. (No Concerns=0, 1, 2, 3, 4, 5= Major Concern)

Depressed __ Sleep Disturbance __ Anxiety/Agitation __ Obsessions __ Paranoia __

Suicidal Ideations __ Substance Abuse __

Have you ever experienced thoughts of suicide? __Yes __No

In the past 2 weeks have you thought of suicide? __Yes __No

Has your ever attempted suicide? __Yes __ No

Medical History

Who is your Primary Care Doctor?

Place of Practice?

Do you take any medications? __ Yes __ No

<u>Medication</u>	<u>Dosage:</u>	<u>Treating:</u>

Please list any chronic illness, disabilities, medical conditions that you have been diagnosed with:

<u>Illness/Disability</u>	<u>Dates:</u>

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Are you have any concerns with the following:

Sleep Yes No Weight Gain/Loss Yes No
Changes in eating habits Yes No Hearing Problems Yes No
Vision Problems Yes No Speech Problems Yes No

If you marked yes to any of the above, please explain: _____

Drug/Alcohol History

First Date of Use:

Last Date of Use:

Alcohol	
Uppers (Meth, Cocaine, Crack, etc.)	
Downers (Valium, Barbiturates, etc.)	
Marijuana	
Hallucinogens	
Inhalants	
Tobacco	
Other (please specify)	

If you checked yes on any of the above, please indicated the substance, frequency of use and duration of use. Do you feel as though you have abused the drugs listed above? If yes, explain.

Please list legal charges and their corresponding dates.

Average number of hours you sleep at night? _____

How long does it take you to fall asleep? _____

Do you wake up during the night? Yes No

How would you rate your overall sleep at the present time?

Poor 1 2 3 4 5 7 8 9 10 (excellent)

Family History

Mothers Name: _____ Fathers Name: _____

Stepmother: _____ Stepfather: _____

Describe you relationship with your parents:

Who do you currently live with?

Name:	Age:	Relationship:	Grade/Job:

Date of current Marriage: _____ Date of Separation or Divorce: _____

Do you have siblings? If so, describe your relationship with them:

Who are you closest to in your family?

Describe your relationship with your significant other:

What are some strengths as a family?

Social History

Do you have friends? __Yes __No

How many close friends do you have? 1 2 3 4 5 or more

List leisure/recreational activities:

List your strengths: _____

List your weaknesses: _____

Developmental History

Were you exposed to drugs or alcohol before birth or early childhood? If yes, please explain. _____

Are there any identified delays in development?

Speech Functioning __Yes __No Hearing Functioning __Yes __No

Visual Functioning __Yes __No Walking __Yes __No

Other Abilities __Yes __No

Have you had any serious injuries or accidents, specifically involving head injury? If yes, please explain. _____
