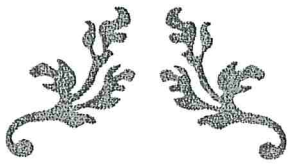

CONFIDENTIAL

NAME: _____

Adult Inventory

Michael Burke, Psy.D. & Associates, P.C

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

Medication	Dosage:	Treating:

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

Illness/Disability	Dates:

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. _____

_____