NEW ENGLAND CENTER
FOR MENTAL HEALTH

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Adult Self-Assessment

Please list the reason for your visit today: _____

_____

Current Medications

Psychiatric medications:

Name	*Dose*	*Frequency*	*When Started*	*Prescribed by*

Non-psychiatric medications (prescription):

Name	*Dose*	*Frequency*	*When Started*	*Prescribed by*

Over-the-counter medications:

Name	*Dose*	*Frequency*	*When Started*	*Prescribed by*

Drug Allergies: _____

_____

Have you received Mental Health services before? _____

Hospitalizations: ☐ yes ☐ no Total # of hospitalizations: _____
Age of first hospitalization: _____

Please list the 3 most current hospitalizations beginning with the most recent:

Dates (from-to)	*Facility*	*Reason*

Have you received **counseling** before?

Name	*Address*	*Phone Number*	*Dates of Treatment*	*Results*

Patient's Name: _____

Have you received **medication evaluations** before?

Name *Address* *Phone Number* *Dates of Treatment* *Results*

_____

_____

Previous Medications

Name *Dose* *Frequency* *Started and Stopped* *Reason for Removal*

_____

_____

Have you had any frightening or traumatic experiences? If yes, please describe.

Accident

- ☐ Yes _____
- ☐ No

Medical trauma

- ☐ Yes _____
- ☐ No

Other

- ☐ Yes _____
- ☐ No

Have you ever experienced sexual or physical abuse? If yes, please describe.

Physical abuse

- ☐ Yes _____
- ☐ No

Sexual abuse

- ☐ Yes _____
- ☐ No

Sexual assault

- ☐ Yes _____
- ☐ No

Neglect by parent(s)

- ☐ Yes _____
- ☐ No

Neglect by relative(s)

- ☐ Yes _____
- ☐ No

Have you ever been a witness to violence? If yes, please describe.

Witness to domestic violence

- ☐ Yes _____
- ☐ No

Witness to other violence

- ☐ Yes _____
- ☐ No

Have you ever used/abused any of the following?

Substance	Date of last use	Age of first use	Method of use	Amount/Frequency of use	Type
Alcohol					
Marijuana					
Tobacco					
Cocaine					
PCP					
Heroin					
Sedatives					
Amphetamines					
Prescription Drugs					
Internet					
Video Games					
Other					

Have you ever felt the need to cut down on your drinking? ☐ yes ☐ no
Have you ever felt annoyed by criticism of your drinking? ☐ yes ☐ no
Have you ever felt guilty feelings about drinking? ☐ yes ☐ no
Have you ever taken a morning eye opener? ☐ yes ☐ no
Have you ever been to a detox program or drug rehab program? ☐ yes ☐ no

If yes, when? _____ where? _____

Medical History

Have you ever had any of the following health problems?	**Yes**	**No**	**When**
1. Loss of consciousness or head injury	☐	☐	
2. Seizures or convulsions	☐	☐	
3. Rashes or skin problems	☐	☐	
4. Meningitis	☐	☐	
5. Asthma	☐	☐	
6. Food allergies	☐	☐	
7. Drug or medication allergies	☐	☐	
8. Pneumonia	☐	☐	
9. Anemia or low blood count	☐	☐	
10. Heart Problems	☐	☐	
11. Kidney or urinary problems	☐	☐	
12. Bowel problems	☐	☐	
13. Trouble with vision	☐	☐	
14. Trouble with hearing	☐	☐	
15. Lack of weight gain	☐	☐	
16. Poisoning or medication overdose	☐	☐	
17. Serious injury	☐	☐	
18. Hospitalization	☐	☐	
19. Surgery	☐	☐	
20. Diabetes	☐	☐	
21. Sexually active	☐	☐	
22. Last menstrual period			

Are you aware of any difficulties/issues during:

- ☐ Birth _____
- ☐ Early childhood _____
- ☐ Elementary school _____
- ☐ Middle school _____
- ☐ High school _____
- ☐ College _____

Family Illnesses

Illness	Biological Mother	Biological Mother's Family	Biological Father	Biological Father's Family	Siblings	Others
Allergies						
Asthma or Emphysema						
Diabetes						
Heart Trouble						
Mental Retardation						
Seizure Disorder						
Depression						
Anxiety						
OCD						
Bipolar Disorder						
ADHD						
Schizophrenia						
Other Psychiatric Disorder						
Learning Difficulties						
Behavioral Problems						
Alcohol Dependency						
Drug Dependency						

Education

Graduated from: ☐ High school ☐ College ☐ Graduate School ☐ Doctorate Program

☐ Job Training ☐ Other (certification, GED):_____

Do you have an interest in pursuing educational opportunities? ☐ Yes ☐ No

Explain:_____

Are current psychiatric or medical issues interfering with your ability to go to school?

☐ Yes ☐ No Explain:_____

Vocational History

Are you currently employed: ☐ Yes ☐ No If yes, where?_____

How long have you been employed there?_____

What is your current position?_____

How many hours do you work each week? _____

Do you enjoy this job? ☐ Never ☐ Occasionally ☐ Usually

Describe your relationship with your current supervisor/boss? ☐ Difficult ☐ Manageable ☐ Enjoyable

If not employed, for how long?_____ Reason for unemployment:_____

_____

Who was your last employer?_____ How long were you there?_____

What was your position?_____ Why did you leave?_____

Have you ever served in the Military? ☐ Yes ☐ No Branch:_____ Discharge Status: _____

Describe work history: ☐ Consistent ☐ Irregular/Sporadic ☐ Frequent Job Loss ☐ Numerous Jobs

Are current psychiatric or medical issues interfering with ability to work? ☐ Yes ☐ no Please explain:_____

_____

_____

Financial Status: ☐ Comfortable ☐ Some Stress ☐ Severe Stress

Legal Problems

- ☐ None
- ☐ Arrests
- ☐ CHINS
- ☐ Probation
- ☐ DYS
- ☐ Victim / Witness
- ☐ Restraining order

Marital History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Live with Significant Other ☐ Widowed

Would you describe your marital relationship as having:

- ☐ No Difficulties
- ☐ Occasional Difficulties
- ☐ Frequent Difficulties
- ☐ Not Currently Married

If married, what are the strengths of the marital relationship?_____

_____

Describe significant marital problems and how they are viewed by both spouses:
Husband:_____

Wife:_____

Have you received counseling for marital problems? Yes ☐ No ☐

If yes, please describe, state who provided services, when seen, and outcome of treatment:

_____

_____

Number of marriages:_____ Length of current marriage/relationship:_____

Length of previous marriages:_____

If widowed, date and cause of spouse's death:_____

_____

With whom do you spend most of your time?_____

What are your hobbies and interests?_____

Current Living Situation: ☐ Rent ☐ Own ☐Other (explain :)_____

How long at this residence?_____ Who lives with you?_____

If you have children, how many?

Birth children __ Adopted children __ Step children__ Other___

Deceased children? ☐ Yes ☐ No Please explain (include date/circumstances)_____

_____

# of Pregnancies:____ # of Incomplete Pregnancies:_____ Date/Circumstances of Incomplete Pregnancies:

_____

Psychological or Medical Issues for Children? Please list below:

Name of child	Age	Diagnosis	Date of diagnosis	Receiving treatment?

Do your children currently or historically have behavioral problems? Please explain (include police involvement if applicable):_____

_____

Is there DSS involvement? ☐ Yes ☐ No Please explain (indicate length of involvement):_____

_____

DSS Office:_____ DSS Worker:_____ Phone:_____

Is there anything else that would be important for your provider to know in order to best meet your clinical needs?_____

_____

_____

_____

Parent History

Biological Father

Date of Birth_____Birthplace_____Religion_____

Ethnic Origin_____Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Biological Mother

Date of Birth_____Birthplace_____Religion_____

Ethnic Origin_____Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Adoptive Step, Foster Father, or Male Guardian
Date of Birth_____ Birthplace_____ Religion_____

Ethnic Origin_____ Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Adoptive, Step, Foster Mother or Female Guardian
Date of Birth_____ Birthplace_____ Religion_____

Ethnic Origin_____ Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____