**Adult Screening Form**

*Please complete this brief questionnaire. I use this to get a better idea of your needs and how I can help meet those needs. Many of the questions may not pertain to you, but I appreciate any information that you can offer.*

**Name: \_\_\_\_\_\_\_ Date of Birth:**

**Primary Care Provider (Doctor)/Psychiatrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. What would you like help with?
2. Please describe what’s causing you the most suffering in your life now.
3. Have there been any recent changes in your life? (Please describe)
4. How long have you been experiencing these thoughts and feelings?
5. Have you ever been hospitalized for mental health issues?
6. Do you have any prior mental health diagnoses/if yes/ please list?
7. Who do you live with?
8. If you work; What kind of work do you do and do you like your work?
9. Are you taking any medications/please list?

1. What do you do for fun?
2. Are religious/spiritual beliefs and practices important to you or your family? If so, please describe briefly:
3. Have you ever had a mental health crisis? YES NO

If yes, what was the outcome?

1. Have you ever had suicidal thoughts or attempts? Please describe.
2. Is there a family history of any of the following? Specify Mother/Father/Grandparent (maternal/paternal)

Mental health issues (ADHD, Anxiety, Depression, Bipolar, etc.) YES NO

Substance use issues YES NO

Family Suicide attempts YES NO

1. Has you ever witnessed or experienced sexual, physical or emotional abuse, assault, or a catastrophic event (fire/car accident/ ect.) ? If so, please describe briefly:
2. What are you most afraid of in life?
3. Has anyone in your family had a problem with drugs or alcohol?
4. What do you hope to get out of counseling?
5. What would your life look like if you received the help you are requesting? Please describe what you hope for and expect to attain a happy life.

***Thank you!***