

**BRIDGEPOINTE PSYCHOLOGICAL &
COUNSELING SERVICES**

Name: _____ SS#: _____ Case ID# _____
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ADULT ASSESSMENT
Page 1

Date: _____

DO YOU HAVE ANY PHYSICAL IMPAIRMENTS OR LIMITATIONS WHICH MAY REQUIRE SPECIAL ACCOMMODATIONS, SPECIAL ARRANGEMENTS, OR MAY AFFECT YOUR TREATMENT (i.e., reading difficulties, hearing loss, vision loss, speech impairment)? Yes No

If yes, please explain:

HEALTH HISTORY:

Do you have any drug/food allergies? Yes No If yes, please specify:

Do you have any physical health problem(s)? Yes No If yes, what condition(s):

Tobacco products use - Current Past Never Used
 Packs per day _____ Other Tobacco Product Use: _____

Weight change in the past 6 months: Yes No Amount: _____
 Significant appetite change over the past month: Yes No

Are you currently on any physician-prescribed medications or regularly take any "over the counter" medication, including any prescriptions for anxiety, depression or other mental conditions? Yes No

If yes, please list all medications below.

Medication/Purpose	Dosage/Times Per Day	How Long?	Do you take this medication consistently?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

In the past, have you taken medication for a mental health condition? Yes No

If yes, please describe: _____

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BEHAVIORAL HEALTH:

Have you had prior mental health services, counseling, or alcohol/drug treatment? Yes No

If yes, please list names and dates below:

OUTPATIENT		INPATIENT	
THERAPIST OR PROGRAM NAME	DATE	HOSPITAL	DATE

Is there any history of emotional or mental problems in the family? Yes No

If yes, please explain: _____

Has anyone in your family had problems with alcohol or other drug use? Yes No

If yes, please explain: _____

Have you ever experienced:

- | | | |
|---|--|---|
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Rape/sexual assault | <input type="checkbox"/> Emotional abuse |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Other significant trauma |

Please comment:

CULTURAL/ETHNIC/SEXUAL/SPIRITUAL:

Cultural/ethnic/racial issues that need consideration: _____

Sexual orientation issues that need consideration: _____

Religious/spiritual issues that need consideration: _____

Client Signature _____

Date _____

Reviewed/Completed by Clinician _____

Date _____

Reviewed/Updated _____

Date _____