Schwartz
Therapy + Wellness, P.C.
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ADULT HISTORY + ASSESSMENT

PLEASE TAKE YOUR TIME AND COMPLETE THE ENTIRE FORM. YOU MAY USE THE BACK IF NEEDED FOR MORE EXPLANATION.

CLIENT NAME: _____ AGE: _____ DATE: _____

Who is providing the history information? _____

I identify my gender as: _____

I found Schwartz Therapy + Wellness, P.C. by way of: _____

Please describe the current complaint or problem as specifically as you can, in your own words: _____

_____

What stressors may have contributed to the current complaint or problem? _____

_____

How long have you experienced this problem, or when did you first notice it? _____

_____

CLIENT DEMOGRAPHICS (Check those which apply)

MALE FEMALE NEVER MARRIED MARRIED DIVORCED COHABITATING WIDOWED SEPARATED

Relationship	Name	Age	Living with you? (check one)		Alive	Deceased	Cause of Death
Father			Yes ☐	No ☐			
Mother			Yes ☐	No ☐			
Spouse			Yes ☐	No ☐			
Child			Yes ☐	No ☐			
Child			Yes ☐	No ☐			
Child			Yes ☐	No ☐			
Child			Yes ☐	No ☐			

Anyone else living with you? _____

FAMILY HISTORY

Number of brothers: _____ Number of sisters: ____ Number of deceased: _____ Step-siblings: ____ Half-Siblings: ___

Please list current or recent family stressors: _____

Within the past year you have experienced:

Loss of an immediate family member? (Check one and if yes, please explain) No: _____ Yes: _____

Loss of a close friend or loved one? (Check, one and if yes, please explain) No: _____ Yes: _____

Divorce or separation from partner? (Check one and if yes, please explain) No: _____ Yes: _____

Loss of job or job opportunity? (Check one and if yes, please explain) No: _____ Yes: _____

Significant family or extended family conflict? (Check one and if yes, please explain) No: ___ Yes: ___

How do you get along with your family? (Check one) Good: _____ Ok: _____ Poorly: _____

Is your family supportive? (Check one) No: _____ Yes: _____

Do you have a supportive system in place? (Check one and please explain) No: _____ Yes: _____

DO YOU HAVE A FAMILY HISTORY OF:

	Yes	No	Whom	Describe
Legal/ financial issues				
Mental illness and/or Substance Abuse				
Domestic Violence				
Suicidal Ideation or Attempts				
Homicide Ideation or Attempts				

Symptoms --*Please check off symptoms you are currently experiences and explain the severity*

- ☐ Depression/feel sad or blue: _____
- ☐ Anger: _____
- ☐ Decreased self-care: _____
- ☐ Crying Spells and/or excessive crying: _____
- ☐ Decreased activity/ everything is an effort/decrease in energy: _____
- ☐ Fear of dying: _____
- ☐ Mood swings: _____
- ☐ Family conflict: _____
- ☐ Racing thoughts: _____
- ☐ Loneliness: _____
- ☐ Greif/Loss: _____
- ☐ Nervous/anxious: _____
- ☐ Job Stress: _____
- ☐ Emptiness/hopelessness: _____
- ☐ Physical Aggression: _____
- ☐ Increase in appetite: _____
- ☐ Hyperactive: _____
- ☐ Guilt/ shame: _____
- ☐ Irritable: _____
- ☐ Sexual problems: _____

Symptoms --*Please check off symptoms you are currently experiences and explain the severity*

- ☐ Paranoia: _____
- ☐ Isolation: _____
- ☐ Suspicious: _____
- ☐ Not seeing friends: _____
- ☐ Worthlessness: _____
- ☐ Too much/ too little sleep/problems falling asleep: _____
- ☐ Nightmares: _____
- ☐ Poor concentration: _____
- ☐ Weight loss /weight gain: _____ (Pounds gained or lost) _____
- ☐ Financial worries: _____
- ☐ Relationship breakup: _____
- ☐ Relationship problems: _____
- ☐ Panic attacks: _____
- ☐ Increased alcohol use: _____
- ☐ Blackouts: _____
- ☐ Increased drug use: _____
- ☐ Withdrawal symptoms: _____
- ☐ Feeling controlled: _____
- ☐ Hearing voices: _____
- ☐ Feeling talked about: _____
- ☐ Seeing things others don't: _____
- ☐ Unusual thoughts: _____
- ☐ Confusion: _____
- ☐ Not getting along with people: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

INDICATE HOW MUCH YOU AGREE WITH THE FOLLOWING:

	Strongly Agree	***Agree***	***Disagree***	**Strongly Disagree**
1. I feel good about myself				
2. I can deal with my problems				
3. I am able to accomplish the things I want				
4. I have friends or family I can count on for help				

INTERESTS: ***Check all that apply***

- ☐ Television
- ☐ Movies/videos
- ☐ Listening to music
- ☐ Cook
- ☐ Play instrument
- ☐ Dance
- ☐ Museums
- ☐ Play sports
- ☐ Computers
- ☐ Being with friends
- ☐ Other: _____
- ☐ Be with family
- ☐ Be alone
- ☐ Build/decorate
- ☐ Eat
- ☐ Read
- ☐ Volunteer work
- ☐ Walk/hike
- ☐ Gamble
- ☐ Shopping
- ☐ Go to school
- ☐ Video games
- ☐ Get high
- ☐ Exercise
- ☐ Write
- ☐ Travel/sight see
- ☐ Skate/roller blade
- ☐ Child care
- ☐ Fix/ repair things
- ☐ Sew/knit/ crochet
- ☐ Study
- ☐ Gardening
- ☐ Sing
- ☐ Draw
- ☐ Pray/read bible
- ☐ Ride
- ☐ Sex

Have you recently lost interest in activities that you normally enjoy? No: _____ Yes: _____

LOSS OF CONTROL: Please explain any areas where you may feel loss of control.

Alcohol use: _____ Drug use, if yes list drug/s used: _____

Prescription use, if yes list prescription/s used: _____

Gambling: _____ Breaking things: _____

Food-overeating: _____ Food-purging: _____

Food- binging: _____ Not eating: _____

Spending money: _____ Hitting: _____

Yelling/ Anger: _____ Burning self: _____

Endangering self: _____Endangering others: _____

Cutting self: _____ Sexual: _____

Other: _____

Have you ever been abused?	Past		Present		What age?	By whom?
Physically abused	No	Yes	No	Yes		
Verbally abused	No	Yes	No	Yes		
Sexually abused	No	Yes	No	Yes		

HARM ASSESSMENT

	Past	**Present**
Suicidal/homicidal thoughts/ideas	Yes: ___ No: ___	Yes: ___ No: ___

If yes explain- nature of thoughts, were you treated? _____

What leads to the thoughts: _____

	Past	**Present**
Suicidal/homicidal urges	Yes: ___ No: ___	Yes: ___ No: ___

If yes explain nature of the urges, frequency, do you have intention: _____

What leads to the urges: _____

	Past	**Present**
Suicidal/homicidal plans	Yes: ___ No: ___	Yes: ___ No: ___

If yes describe the plan_____

If you went home today, do you think you would hurt yourself? _____

	Past	**Present**
History of self-harm (cutting self, burning, hitting, etc.)	Yes: ___ No: ___	Yes: ___ No: ___
Prior suicide/ homicide attempt	Yes: ___ No: ___	Yes: ___ No: ___

If yes explain in detail: _____

	Past	**Present**
Is your partner afraid of you	Yes: ___ No: ___	Yes: ___ No: ___

If yes explain in detail: _____

	Past	**Present**
Are your children afraid of you	Yes: ___ No: ___	Yes: ___ No: ___

If yes explain in detail: _____

	Past	**Present**
Other self-harm behaviors	Yes: ___ No: ___	Yes: ___ No: ___

If yes explain in detail: _____

Has any family member attempted or committed suicide? Yes: ___ No: ___ If yes, who: _____

Have you ever abused others?	Past		Present		Who?	What was your age?
Physically abused	No	Yes	No	Yes		
Verbally abused	No	Yes	No	Yes		
Sexually abused	No	Yes	No	Yes		

Circumstances: _____

Please check all that you may do that is aggressive or threatening, accidentally or on purpose, to you or someone important in your life:

- ☐ Threatened: _____
- ☐ Throw things: _____
- ☐ Slammed things: _____
- ☐ Yelled: _____
- ☐ Screamed: _____
- ☐ Hit: _____
- ☐ Chocked: _____
- ☐ Punched Wall: _____
- ☐ Pushed: _____
- ☐ Other: _____

EMPLOYMENT

Did your employer refer you for help? (Check one): Yes: ___ No: ___
Current Job: _____ Employer: _____
Are you experiencing problems at work? Yes: ___ No: ___, Describe: _____
Are there any present or past disciplinary issues at work? Yes: ___ No: ___, Reason:
_____
Have you missed time at work or school? Yes: ___ No: ___, Reason: _____
Have you ever been fired? Yes: ___ No: ___, Reason: _____

FINANCIAL

Have you ever filed bankruptcy? Yes: ___ No: ___ (if yes, when?) _____
Are you currently experiencing any financial concerns? Yes: ___ No: ___, Describe:
_____

SEXUAL/GENDER

Do you have any sexual and/or gender concerns? No/ Yes? Describe as full as you can:
_____

LEGAL

Are you on probation? Yes: ___ No: ___, Describe charges: _____
Are you on parole? Yes: ___ No: ___, Describe charges: _____
Have you ever been arrested? Yes: ___ No: ___

Date of event	Charge	Convicted	Sentence	Completed

Court Dates Pending? Yes: ___ No: ___, Describe: _____
Pending Lawsuits? Yes: ___ No: ___, Describe: _____

MILITARY

Yes: ___ No: ___ Type of Discharge: _____
Branch: _____Dates of service: _____
Combat experience? Yes: ___ No: ___, Describe: _____

Are you troubled by your experiences? Yes: ___ No: ___, Describe: _____

EDUCATION

Last grade completed: _____Degree: _____Are you in school now? Yes: ___ No: ___
Did you ever receive special services at school? Yes: ___ No: ___ Describe: _____
Have you ever been identified as having learning problems? Yes: ___ No: ___ Describe:
_____
How would you evaluate your reading skills? Poor/ Average/ Good: _____
How would you evaluate your math skills? Poor/ Average/ Good: _____

ETHNIC/CULTURAL

Background: _____
Any concerns in this area? Yes: ___ No: ___, Describe: _____

RELIGION

Background: _____ Are you actively involved? Yes: ___ No: ___

SPIRITUAL ORIENTATION

What gives your life meaning? _____
What are sources of satisfaction, good feelings and/or self-esteem? _____
_____
List any religious or spiritual concerns: _____

MENTAL HEALTH TREATMENT

Outpatient?	Yes	No	When	Where
Inpatient?				
Day Treatment?				
Other treatment experiences?				

Have you ever used or abused alcohol, drugs, and/or medications in any inappropriate way? No/ Yes, please explain: _____
Have you accidentally or purposely overdosed? Yes: ___ No: ___, please explain: _____
Have you ever had a seizure from substance use/abuse? Yes: ___ No: ___, please explain:
_____
Have you ever suffered a stroke from substance use or abuse? Yes: ___ No: ___, please explain: _____
Have alcohol, drugs and/or medications interfered with your daily functioning? Yes: ___ No: ___, please explain: _____
Has anyone ever expressed concern about your substance use or abuse? Yes: ___ No: ___
Who/When: _____
In the past 6 months have you ever felt annoyed by people criticizing your drinking or drug use? Yes: ___ No: ___, please explain: _____
Have you ever been treated for substance abuse, substance dependence, or possible (accidental) overdose? Yes: ___ No: ___, please explain: _____

SUBSTANCE ABUSE TREATMENT

Inpatient treatment program?	Yes	No	When	Where
Intensive outpatient program?				
Outpatient program?				

MEDICAL

Primary Care Physician: _____ Phone: _____ Fax: _____
Address: _____
Date of last physical: _____
Do you eat a balanced diet? Yes: ___ No: ___ (if no describe): _____
Do you exercise? Yes: ___ No: ___ (if yes describe): _____
Weight loss? Yes: ___ No: ___ (if yes how much in the last 3 months?): _____
Weight gain? Yes: ___ No: ___ (if yes how much in the last 6 months?): _____
In general, would you say your health is: Excellent/Very Good/ Good/ Fair/ Poor: _____
Please indicate if you have a serious or chronic medical condition: Asthma/ Diabetes/ Heart Disease/ Back Pain or other Chronic Pain/ Other Condition/s: _____
In the past 6 months, how many visits to a medical doctor? _____
In the past 6 months, how many days were you unable to work because of your physical or mental health? _____ days.
In the past 6 months, how many days were you able to work but had to cut back due to your physical or mental health? _____ days.
Additional comments: _____

FOR WOMEN ONLY

Number of births: _____ Abortions: _____ Miscarriages: _____ Still births: ____
Do you have PMS? Yes: ___ No: ___ Are you pregnant? Yes: ___ No: ___ Are you Menopausal? Yes: ___ No: ___

PLEASE CHECK OFF ALL ITEMS THAT APPLY TO YOU NOW OR IN THE PAST.

Medical concern	Present	Past	Medical concern	Present	Past	Medical concern	Present	Past
Allergies			Circulation			Major accidents		
Asthma			Weight gain			Broken Bones		
Ulcers			Weight loss			Appetite Disturbances		
Seizures			STD's			Low Blood Pressure		
Stomach Problems			AIDS			High Blood Pressure		
Pancreatitis			Cancer			Heart Disease		

Continued: PLEASE CHECK OFF ALL ITEMS THAT APPLY TO YOU NOW OR IN THE PAST.

Medical concern	**Present**	**Past**	**Medical concern**	**Present**	**Past**	**Medical concern**	**Present**	**Past**
Liver Disease			Major Surgery			Prolapsed mitral valve		
Thyroid Disease			Neck Tension			Lupus		
Chronic fatigue			Headaches			Obesity		
Insomnia			Back Problems			High Cholesterol		
Speech problem			Diabetes			Irritable bowel		
Hypoglycemia			Vision Problems			Chronic pain		
Hearing Problems			HIV			Impotence		
Other			Other			Other		

PLEASE FILL OUT ALL REVELANT PARTS

Current medication/s Name:	Amount	How often per day?	Why do you take this medication?

List other vitamins or herbal supplements you take: _____
List other medical concerns: _____

Additional information you would like to share: _____
_____
_____