Stephen Mardell, MFT
30101 Agoura Court, Suite 204
Agoura Hills, CA 91301
(818) 706-0040

Adult Initial Assessment

Please fill out this biographical background form as completely as possible. All information is confidential as outlined in the Office Policy form. If you do not desire to answer any question, merely write "Do not care to answer."

NAME: _____**M/F:**_____**DATE:**_____

DATE OF BIRTH: _____**PLACE:** _____**AGE:** _____

ADDRESS:_____**CITY:**_____ **ZIP:**_____

SOCIAL SECURITY #:_____ **E-MAIL:** _____

TELEPHONE: H: _____**W:** _____**CELL:**_____

OCCUPATION:_____**EMPLOYER:**_____

EMPLOYER ADDRESS:_____

EMERGENCY CONTACT:_____**PHONE:**_____

MEDICAL DOCTOR/S (name /phone): _____

REFERRAL SOURCE: _____

May I inform this person that you have consulted with me?_____

HIGHEST GRADE/DEGREE: _____ **TYPE OF DEGREE:** _____

PRESENTING PROBLEM (be as specific as you can: When did it start, how does it affect you.)

_____

_____

_____

CURRENT MARITAL STATUS: _____ **Live with someone:** ____ **Name:** _____**#Yrs:**____

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e. friendly, distant, physically/emotionally abusive, loving, hostile):

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____ **Occupation:** _____

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CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1._____

2._____

3._____

4._____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

Mother:_____

_____

Step-parents:_____

_____

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time:

_____

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____

2._____

3._____

4._____

5._____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

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FAMILY MEDICAL AND PSYCHIATRIC HISTORY (Describe any physical or mental illness that runs in the family including depression or suicide)**:**

FAMILY HISTORY OF ALCOHOL/DRUG PROBLEMS (Describe any abuse of substances that runs in the family)**:**

FAMILY HISTORY OF VIOLENCE OR EMOTIONAL/PHYSICAL ABUSE (Towards you or other members of your family):

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning.end), estimated no. of sessions, name,degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1.

2.

****** *USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS***

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

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Prescription Drugs:

Type	Amount	Frequency	Date last used

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

Coffee (#_____cups/daily)

Cigarettes (#_____ per day)

Alcohol (#_____ drinks/daily_____ or weekly_____) Date last drank:_____

Street drugs (Type):_____Frequency:_____

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

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Please indicate how the following symptoms/problems/complaints are effecting you:
1)Little effect 2)Some effect 3)Much effect 4)Significant effect
(Leave blank if no effect)

___Eating habits/Appetite: eating more, eating less
___weight change; amount ___
___binge; purge
___Sleep: Trouble falling asleep; Trouble staying asleep; Trouble waking up; Average # hours sleep_____ #Naps_____
___Decreased energy/Fatigue
___Sexual functioning
___Loss of interest in activities
___Tearfulness
___Hopelessness/Helplessness
___Decreased attention span
___Inattentive/Distractible
___Memory: Long term;short term
___Difficulty planning ahead
___Spending sprees
___Rapid heartbeat
___Phobia
___Sweating
___Trouble Breathing
___Flashbacks of traumatic events
___Nightmares
___Racing thoughts
___Impulse control - hyperactive
___Mood changes
___Anxious/nervous
___Worry/fear
___Hearing voices
___Seeing things that are not there
___Stealing
___Anger outbursts
___Panic attacks - Frequency

Rate how the problems/symptoms/complaints are impacting areas of functioning:
(Leave blank if no effect) 1)Mild 2)Moderate 3)Severe

___ Marriage/Relationship
___ Work/School
___ Family
___ Friendships
___ Financial situation
___ Physical health
___ Social interests
___ Leisure activities
___ Clubs/Group memberships
___ Legal
___ Housing
___ Attending to daily living activities (shower, grooming, self care, etc)
___ Spirituality
___ Other:_____

What gives you most joy or pleasure in your life:

_____

_____

_____

What are your main worries and fears:

_____

_____

_____

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What do you identify as your strengths:

What do you identify as your weaknesses:

What are your goals for treatment:

Please add anything in the space provided any other information you would like me to know about you and your situation.

Patient Name:_____ **Date:**_____

Patient Signature:_____