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ADULT ASSESSMENT & REGISTRATION FORM

(PLEASE PRINT OR TYPE)

Today's date:

CLIENT INFORMATION

Last Name:	First Name:	Middle:

Is this your legal name? ❑ Yes ❑ No	Nicknames:	❑Miss ❑Ms. ❑Mrs. ❑Mr.	Birth date: / /	Age:	Sex: ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Place of birth	Where did you grow up:	Handedness ❑ Right ❑Left ❑Both

Native Language:	Other Language(s) You Speak Fluently:

Ethnicity:	☐ African American	☐ Asian	☐ Caucasian	☐ Hispanic	☐ Native American	☐ Other

Street address:

City:	State:	Zip:	Country

Home phone: Ok to Call? Yes ❑ No ❑	Cell phone: Ok to Call? Yes ❑ No ❑	Best Time to Call: * (see below)

* Calls will be discrete, please list any restrictions

E-mail address? ❑ Ok to send email communications? Yes ❑ No ❑

EDUCATION

	FROM - TO	SCHOOLS	ANY SPECIAL EDUCATION CLASSES?	ADJUSTMENT TO SCHOOL	DID YOU GRADUATE? / HIGHEST DEGREE
ELEMENTARY					
HIGH SCHOOL					
VOCATIONAL / TRADE					
COLLEGE					

Name: DOB:

GRADUATE					

WORK / EMPLOYMENT HISTORY

ARE YOU CURRENTLY: ☐EMPLOYED FULL TIME ☐EMPLOYED PART TIME ☐UNEMPLOYED ☐RETIRED ☐ON DISABILITY ☐ON LEAVE
(check all that apply) ☐ON FULL DUTY ☐ON MODIFIED DUTY ☐SUSPENDED WITH PAY ☐SUSPENDED WITHOUT PAY ☐OTHER:

DATE STARTED WITH CURRENT EMPLOYER:	YOUR CURRENT RANK OR TITLE:

	FROM - TO	EMPLOYER NAME/LOCATION	POSITION	ANY DISCIPLINARY ACTIONS?	REASON FOR LEAVING
CURRENT EMPLOYER					
PREVIOUS EMPLOYER					
PREVIOUS EMPLOYER					
PREVIOUS EMPLOYER					

HAVE YOU SOUGHT OR HAD A FITNESS FOR DUTY ASSESMENT IN THE PAST? ☐ YES ☐ NO ***If yes please list below***

DATE (S) OF ASSESSMENT	ASSESSOR'S NAME OR PRACTICE NAME	WERE YOU FOUND FIT FOR DUTY? YES / NO

MILITARY SERVICE INFORMATION

ENTERED INTO SERVICE		SERVICE NUMBER	SEPERATED FROM SERVICE		BRANCH OF SERVICE	GRADE, RANK OR RATING, ORGANIZATION
DATE	PLACE		DATE	PLACE		

Name: DOB:

FAMILY OF ORIGIN HISTORY

RELATIONSHIP / NAME	CURRENT AGE OR DATE DECEASED	ILLNESSES OR CAUSE OF DEATH IF DECEASED	HIGHEST LEVEL OF EDUCATION	OCCUPATION	MAY I CONTACT THIS PERSON (YES/NO)
MOTHER					
FATHER					

WERE YOU RAISED BY: ☐ONE PARENT ☐BOTH PARENTS ☐ADOPTVE PARENTS ☐GUARDIANS ☐RELATIVES ☐OTHER:

HOW MANY SIBLINGS DO YOU HAVE: YOUR BIRTH ORDER:

BESIDES YOUR PARENTAL CARETAKERS OR SIBLINGS, WERE THERE OTHER ADULTS LIVING IN THE HOUSE YOU GREW UP IN?

☐YES ☐NO If Yes, were they: ☐Grandparents ☐Other Relatives ☐Family Friends ☐Renters/Lodgers ☐Other

MARITAL HISTORY

	NAME	SPOUSE'S AGE AT TIME OF MARRIAGE / YOUR AGE AT TIME OF MARRIAGE	YOUR AGE AT TIME OF DIVORCE / WIDOWED OR NOT APPLICABLE	REASON FOR ENDING	MAY I CONTACT THIS PERSON (YES/NO)
1ST		/			
2ND		/			
3RD		/			

CHILDREN

	NAME / SEX	CHILD'S CURRENT AGE	YOUR AGE WHEN CHILD WAS BORN	CHILD'S CURRENT SCHOOL GRADE OR OCCUPATION	LIVES WITH ME? YES / NO
1ST					
2ND					
3RD					
4TH					
5TH					

Name: DOB:

MEDICAL CARE & HISTORY

Month and year of your last physical:		Any new problems or major findings? ☐ YES ☐ NO	
Are you currently being treated by a doctor or taking medications prescribed by a doctor? ☐ YES ☐ NO			
If yes, state the problem or condition(s) you are being treated for:			
Please list any medications you are currently taking, prescribed and over the counter:			
Medication	Dosage	Prescribed and supervised by	Length of time taken
Primary Physician's Name:			
I GIVE CONSENT TO CONTACT PHYSICIAN: ❑ YES ❑ NO		Phone:	
Physician Street address:			
City:		State	Zip

HAVE YOU EVER BEEN HOSPITALIZED? ☐ Yes ☐ No	If yes: ☐ Medical ☐ Psychiatric ☐ Work Related	
Dates From / To	Reason / Incident	Location/Facility

PSYCHIATRIC/THERAPEUTIC CARE

ARE YOU CURRENTLY BEING TREATED BY A PSYCHIATRIST, THERAPIST, OR COUNSELOR? ☐ YES ☐ NO		
If yes, please state the problem(s), issue(s) or condition(s) that caused you to seek treatment:		
Primary Therapist or Counselor Name:		
I GIVE CONSENT TO CONTACT THIS PERSON: ❑ YES ❑ NO	Phone:	
Street address:		
City:	State	Zip

THIS IS A STRICTLY CONFIDENTIAL PATIENT MEDICAL RECORD. THE LAW STRICTLY PROHIBITS REDISCLOSURE OR TRANSFER WITHOUT PATIENT CONSENT. IT IS TO BE USED TO GUIDE AND FACILITATE THE ASSESSMENT CONDUCTED BY DR. RAFANELLO ONLY, UNLESS PATIENT GIVES CONSENT TO RELEASE.

Name: DOB:

HAVE YOU PREVIOUSLY SOUGHT COUNSELING / MENTAL HEALTH TREATMENT ASSESMENTS? ☐ YES ☐ NO ***If yes please list below***				
Disorder	Medications	For How Long?	Counselor	Helpful?
☐ Depression				
☐ Anxiety				
☐ ADHD				
☐ Bipolar Disorder				
☐ PTSD				
☐ Substance Use Disorder				
☐ Other				

Do you have any problems getting to sleep? ❑ Yes ❑ No Please Describe

_____

Any problems with appetite, eating, or gaining or losing weight recently? ❑ Yes ❑ No Please Describe

_____

Do you have any allergies? ❑ Yes ❑ No Please Describe

_____

Any history of head trauma? ❑ Yes ❑ No Please Describe

_____

ABUSE HISTORY

❑ I was not abused in any way ❑ I was abused

ALCOHOL / CHEMICAL USE

Have you ever felt the need to cut down on your drinking or drug use at any point in your life? ❑ Yes ❑ No

Have you ever felt annoyed by criticism of your drinking or drug use? ❑ Yes ❑ No

Have you ever felt guilty about your drinking or drug use? ❑ Yes ❑ No

Please indicate below any of the drugs or alcohol that you have used in the past 10 years

❑ Caffeine ❑ Tobacco ❑ Alcohol ❑ Marijuana ❑ Cocaine ❑ Heroin ❑ PCP ❑ Inhalants

❑ Methamphetamine/Uppers ❑ Ecstasy ❑ Pills (please indicate) _____

Have you ever had? ❑ Blackouts ❑ Bad reactions ❑ Withdrawal symptoms ❑ Overdoses ❑ Detoxification in a hospital

Name: DOB:

HAVE YOU EVER RECEIVED TREATMENT FOR CHEMICAL USE? ❑ YES ❑ NO *If yes please list*					
DATES FROM/TO	AGENCY/PROVIDER	VOLUNTARY (YES OR NO)	INPATIENT OR OUTPATIENT	PARTICIPATION IN AFTERCARE / TREATMENT	WAS IT EFFECTIVE (YES / NO)

LEGAL HISTORY

Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No If yes, please explain

_____

_____

Is your reason for coming to see me related to an accident or injury? ❑ Yes ❑ No If yes, please explain.

_____

_____

Are you required by a Court, the police, or a probation/parole officer to have this appointment? ❑ Yes ❑ No If yes, please explain.

_____

_____

Your current attorney's name and number if you are involved in a legal proceeding:

Name _____ Phone _____

Are there any other legal issues or Court proceedings I should know about?

_____

If an assessment is to be presented to the Court, when is your next Court date scheduled? _____

Name: DOB:

List all *Criminal* contacts with police, Courts, and jails/prisons you may have had

DATE	CHARGE	FEDERAL/STATE/ MUNICIPAL/COUNTY/ CITY	SENTENCE	PROBATION/PAROLE OFFICER NAME	ATTORNEY'S NAME

IN CASE OF EMERGENCY		
NAME OF LOCAL FRIEND OR RELATIVE		
RELATIONSHIP TO YOU		
I GIVE CONSENT TO CONTACT THIS PERSON REGARDING THE NATURE OF THE EMERGENCY ❑ Yes ❑ No		
HOME PHONE	CELL PHONE	
City:	State	Zip

EXAMINEE SIGNATURE *Date*

_____

PRINTED NAME *Date*

_____