WHOLENESS HEALING CENTER
"Heart Centered Wellness For Life"

Adult Clinical Assessment

Date:	Name:	
Gender: M F	Birth:	Age:
Referral Source:		
Address:		Phone: Cell:
Person completing form:	Spouse's Name	

EMERGENCY CONTACT: _____
GUARDIAN: _____
PSYCHIATRIC ADVANCE DIRECTIVES: _____
MARITAL STATUS: _____
INSURANCE: _____
ETHNICITY: _____
MILITARY HISTORY: _____

SOCIAL HISTORY

Current living situation:

Have you moved frequently or had recent changes to your living situation?

SPIRITUALITY

Are you actively involved in any religious practices?

Do you have any concerns about spirituality?

WORK HISTORY

Are you currently employed?

Do you have any activities that you are involved in such as volunteer work, groups, organizations, etc?

FAMILY HISTORY

Biological father's name: _____ Date of birth: _____
Address: _____

Biological mother's name: _____ Date of Birth: _____
Address: _____

Parents' date of marriage: _____ Date of separation or divorce: _____

Describe your relationship with your parents:
Mother: _____
Father: _____
Adoptive mother, guardian, stepmother, female significant other: _____
Adoptive father, guardian, stepfather, male significant other: _____

Name siblings, ages, and current residences.

NAME	AGE	GENDER	RESIDENCES
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____

Relationships with/Support from siblings:
_____
_____

Spouse's name: _____ Date of birth: _____
Relationship: husband wife foster stepparent significant other other: _____
Address: _____
Date of marriage: _____ Date of separation or divorce: _____
Previous marriages:
_____
_____
_____
_____

List the all children and circle the corresponding information:

NAME	AGE	GENDER	RELATIONSHIP
_____	_____	M F	full half step adoptive foster
_____	_____	M F	full half step adoptive foster
_____	_____	M F	full half step adoptive foster
_____	_____	M F	full half step adoptive foster

Who currently resides in your home?

NAME	AGE	GENDER	RELATIONSHIP
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____

Family History of significance: mental illnesses, chemical dependency and treatments, vocational history, divorces, marriages, separations, deaths, incarcerations:
_____
_____
_____
_____

List any other people who have been especially significant in your life:

NAME	AGE	GENDER	RELATIONSHIP
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____

MENTAL/EMOTIONAL HEALTH HISTORY

Have you ever received counseling or inpatient therapy? YES NO

Has the family participated in any type of family therapy? YES NO

Do you take any psychotropic medication?

DEVELOPMENTAL HISTORY

Has there been any significant situations from your birth or early development?

Were you as a child ever placed out of the home? YES NO

MEDICAL/DENTAL HISTORY

Do you have a primary care physician?

Do you have any significant disease, injuries, surgeries or illnesses?

Do you have any known allergies?

Are you prescribed any medication? YES NO

Do you take the medication as prescribed? YES NO

Do you take any over the counter medication on a regular basis?

Please indicate medication specifics below:

Medication	Dose	Reason	Prescribing Physician

Have you had any pregnancies, births or fathered children?

EDUCATIONAL HISTORY

Do you attend, graduate, or complete any formal education?

LEGAL HISTORY

Do you have any history of crimes or legal charges?

Have you ever been a victim of abuse?			By whom?
Physical	YES	NO	By whom? _____
Emotional/verbal	YES	NO	By whom? _____
Sexual	YES	NO	By whom? _____
Neglect	YES	NO	By whom? _____

Have you ever witnessed violence or abuse? YES NO

Have you ever experienced other traumatic incidents? YES NO

Have you ever been a perpetrator of abuse? YES NO