Rasmussen Counseling LLC

Assessment History Form

Stressful Events: (List any recent stressful events):_____

_____

_____

Medical History: Check all that apply

	Chest Pain/Tightening		Asthma		Shortness of Breath
	Hypertension		Dizzy spells/fainting		TB Lung Disorder
	Heart attacks		Ulcers		Cancer
	Stroke		Diabetes		Skin Disorders
	Headaches		Arthritis		Hepatitis
	Glaucoma		Hearing Difficulty		Cataracts
	Allergies		Memory Loss		Digestive Problems
	Eczema		Hemorrhoids		UTI's
	Depression		Kidney Problems		Blood in stool
	Seizures		Movement Disorders		Tics
	Other Neurological Disorders		High Cholesterol		High Triglycerides

Past History of Head Trauma:_____

_____

Past Surgeries, Hospitalizations or other medical problems:_____

_____

(Females only): Type of Birth control (if applicable) Dosage: _____

Are you pregnant: ☐ Yes ☐ No Breast feeding: ☐ Yes ☐ No

Number of previous pregnancies: _____ Number of Live Births:_____

Number of Children:_____

Drug and Alcohol History:

Cigarettes/Tobacco: Do you smoke or chew: ☐ Yes ☐ No If yes number of years_____

If yes number of years____ Packs per day: _____ How long since your last cigarette:_____

If not smoking or chew have you in the past?☐ Yes ☐ No

Caffeine: Do you drink coffee or other caffeinated beverages: ☐ Yes ☐ No

Cups or 8 oz per day:_____ Type of Beverages: _____

Alcohol: Do you drink currently or have you in the past year? ☐ Yes ☐ No

How many times per week?_____ Type of beverages_____

Average amount consumed per week:_____ How long have you been drinking?_____

If not current have you consumed in the past?☐ Yes ☐ No History of DWI?☐ Yes ☐ No

Current Drug History:

Do you use drugs or elicit substances now or in the past year? ☐ Yes ☐ No

Type: _____ How much/often/long?_____

_____

Past History of Drug Use: Have you used Drugs in the past? ☐ Yes ☐ No

Type: _____ How much/often/long?_____

_____

How long since last use?_____

Are you in any treatment/programs to remain sober? _____

Risk Assessment:

Do you have thoughts of harming yourself? ☐ Yes ☐ No
Do you have a plan for harming yourself ☐ Yes ☐ No
Have you attempted to harm yourself in the past? ☐ Yes ☐ No
Have any relatives committed suicide? ☐ Yes ☐ No
Have you assaulted or threatened anyone recently? ☐ Yes ☐ No

Have you ever been in trouble because of your temper or anger? ☐ Yes ☐ No
Does drinking or drug use ever lead you to become violent? ☐ Yes ☐ No

Childhood Development:

Milestones: Were motor/walking milestones met at age appropriate? ☐ Yes ☐ No
Were Vocalizations/talking milestones met at appropriate age? ☐ Yes ☐ No
Did the patient have friends as a child? ☐ Many ☐ few ☐ None
Does the patient have friends now? ☐ Many ☐ few ☐ None

Abuse History: History of abuse as a child/teen:
Physical: _____

_____

_____

Sexual: _____

_____

_____

Emotional: _____

_____

_____

Traumatic Events: Please describe any traumatic events you experienced or witnessed as a child or teen or adult: such murder, beating, rape: _____

_____

_____

Family Structure/History: With whom did you grow up? _____

_____

Current family structure/makeup:_____

_____

Please identify any recent changes to your family structure or make up: _____

_____

_____

Family History: In the sections below please answer questions to your individual family history. Note to pay attention to anyone with similar symptoms to you. Check boxes.

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Maternal Relative	Paternal Relatives
High Blood Pressure										
Epilepsy										
Seizures										
Cancer										
Heart Attack										
Stroke										
Diabetes										
Asthma										
Dizzy Spells/fainting										
Movement Disorders										
Tics										
Other Neurological Disorders										
Depression										
BiPolar Disorder										
Schizoprhenia										
ADHD										
Concentration Problems										
Hyperactivity										
Anger Outbursts										
Periods of Agitation										
Nervous Breakdowns										
Anxiety										
Panic Attacks										
Obsessive thinking or Worry										
Compulsions										
Attempted Suicide										
Committed Suicide										
Alcohol										
Drug Use										
History of Abuse Past/Present as Abuser										
History of Abuse Past/Present as Victim										