



4485 Tench Road, Suite 1220
Suwanee, GA 30024
770-378-6835

Social Support, Relationships and Self-Care

Are you currently in a relationship? Yes No For how long? _____

Marital Status:	
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Life Partner <input type="checkbox"/> Co-Habitation <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Number of Previous Marriages: 0	Length of Time with current partner:

On a scale of 1-10 (1 being miserable and 10 representing excellent) how would you rate your current relationship? _____

Sexual Orientation:	
<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning	
Gender Expression:	

Household Composition at time of Assessment		
Name	Relationship	Age

Do you consider yourself a spiritual person? Yes No

If so how do you practice or engage in your spiritual life?

Briefly describe your diet and exercise patterns: _____

Do you feel as though you have a supportive network of friends? Yes No

What coping mechanisms have you used in the past which you felt were helpful?

Name: _____ Date: _____



4485 Tench Road, Suite 1220
 Suwanee, GA 30024
 770-378-6835

What would you say you do to care for yourself on a regular basis? Include exercise, eating well, or hobbies _____

Education and Career

High School / GED College Degree Graduate Degree (or higher)

Employment Satisfaction 1 2 3 4 5 6 7
POOR Excellent

What type of work do you do? _____

What would you describe as your strengths? _____

Family:

Family of Origin (relationships/problems/issues). Describe family functioning and dynamics. Describe your relationship with biological parents and/or guardians, and siblings.

RISK AND TRAUMA ASSESSMENT (INCLUDE ABUSE/NEGLECT)	
<i>Check all that apply</i>	
Suicidality	<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent w/o means <input type="checkbox"/> Intent w/means
Details:	
Homicidality	<input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent w/o means <input type="checkbox"/> Intent w/means
Details:	
Neglect	<input type="checkbox"/> None <input type="checkbox"/> Emotional <input type="checkbox"/> Nutritional <input type="checkbox"/> Educational <input type="checkbox"/> Medical

Name: _____ Date: _____



4485 Tench Road, Suite 1220
Suwanee, GA 30024
770-378-6835

Details:

Abuse None Physical Sexual Verbal/Emotional Family Violence

Details:

Trauma None Separation from family Violence / Injury Death Other
Directly Experienced Witnessed Learned it Happened to Someone Close Repeated Exposure (Vicariously)

Provide Details of Trauma Experienced or Witnessed below. *Include: Intrusive Symptoms, Avoidance Behaviors, Negative Alterations in Cognition and Mood.*

Please describe your presenting problem:

What are your goals for therapy?

Name: _____ Date: _____