



Ascension Behavioral Health

1549 Clairmont Rd.,
Suite 108
Decatur, GA 30033
(732) 733.6413
PSY003613
NPI: 1548518178
Tax ID: 47-2327377

Demographics & Self-Assessment Form

Name: _____

Today's Date: _____

Name of person filling out this form (if not client):

Full Local Address:

Gender: Male / Female / Transgender

Race: _____

Date of Birth: _____ Age: _____

Phone (best number(s) to reach you):

Is it OK to leave messages at this number? Y / N

Preferred Email Address:

Is it OK to email you? Y / N

*Please be aware that email may not be confidential

Name, number and full address of person to call in case of emergency:

Relationship to emergency contact above:

Marital Status: Single / Never Married / Committed Relationship / Engaged /
Married / Separated / Divorced / Widowed / Living Cooperatively / Marriage
Annulled (Circle One)

Years Married: _____ Years Divorced: _____ Length of Separation: _____

Spouse Name: _____ Age: _____

Spouse Occupation:

Number of Children: _____

Education:

- High school or earlier
- College or University
- Post-Graduate

Occupation or School Name (and location):

If utilizing insurance to assist with payment for services, please include the following information:

Insurance Plan: _____ Member ID Number: _____
Group Number: _____

Referred by: _____

Please describe the reason for you are seeking psychotherapy at this time:

Please describe your symptoms from the time they started to the present:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Y / N. Please describe these services:

Have you had previous psychotherapy? Y / N, at previous therapist's name:

Are you currently taking prescribed psychiatric medications? (antidepressants, anti-anxiety or others?) Y / N. Please list and describe your response to them.

If no, have you previously been prescribed psychiatric medication? Y / N. Please list and describe your response to them.

What are your goals for therapy?

Suicide:

- I have never thought about suicide.
- I have thought about suicide in the past.
- I have attempted suicide in the past.
- I am having thoughts of suicide right now.

Please describe any and all thoughts of suicide (If you checked any of the boxes above other than "I have never thought about suicide," please write when was the last time and how?):

Harm to Others:

- I have never thought about harming someone else.

- I have thought about harming someone else.

Please describe any and all thoughts of harming someone else (If you checked “I have thought about harming someone else,” please write when was the last time, and how?):

How is your physical health at this time?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Do you smoke? Y / N. How much and for how long?

Do you drink caffeine (coffee, tea or soda)? Y / N. How much?

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Please list any medications you are using to address above health concerns:

Please list any past surgeries or accidents and age they happened:

Are you having any problems with sleep habits? Y / N. If yes, mark where applicable below:

- Sleeping too little

- Sleeping too much
- Poor quality
- Disturbing dreams, Sleepwalking, Other Difficulties

Are you having difficulty with appetite or eating habits? Y / N. If yes, mark where applicable below:

- Eating less
- Eating more
- Binge eating
- Restricting my eating
- Purging

Have you experienced significant weight loss in the last 5 years? Y / N. Please describe any increase or decrease in weight over the past 5 years:

Do you regularly use alcohol? Y / N.

How many drinks do you consume in the average day?

- None
- 1-2
- 2-3
- 3-4
- 4-5
- 5 or more

What time of day do you normally consume alcohol?

- Early Morning
- Mid Morning
- Early Afternoon
- Mid Afternoon
- Evening
- After 10:00pm

Have you, or someone else, thought that you were drinking too much? Y / N. Please describe:

Have you ever taken any of the following drugs?

- Marijuana
- Amphetamines/Speed
- Heroin/Opiates
- PCP
- LSD, Mushrooms, or other hallucinogens
- Cocaine/Crack
- Barbiturates/Sedatives/Downers
- Pain Killers
- Any medication not prescribed to you

If you checked any drug above, what circumstances did you take this/these drugs under? Please describe and include last use:

When did you most heavily use drugs or alcohol? Please describe:

Has anyone in your family (immediate family members or relatives) experienced difficulties with depression or anxiety? Has anyone experienced any traumas or alcohol/substance abuse?

Have you experienced any significant traumas in your childhood? Please list and describe:

Mother's age and occupation (If deceased, age of death):

Father's age and occupation (If deceased, age of death):

Brother's age and occupation (If deceased, age of death):

Sister's age and occupation (If deceased, age of death):

Please provide any additional information you think it would be important for Dr. Abrams to know:

Signature:
