Carolina Counseling Services

Adult Comprehensive Clinical Assessment

Name: _____ Date of Birth: _____ Age:_____ Gender: ___M ___ F

Marital Status: (circle one) *single/never married married separated divorced widowed living with someone*

Please CIRCLE ALL of the following that describe how you have been feeling lately:

Sad anxious depressed frightened guilty angry ashamed aggressive resentful worthless tearful irritable confused extreme up extreme down jealous hopeless helpless

Describe any other feelings you have had: _____

_____

Do you participate in regular exercise: Yes No (circle) Hobbies? _____

Describe your current working environment: _____

Have you had any changes in your sleeping habits? Yes No (circle) describe: _____

Have you had any changes in eating habits? Yes No (circle) describe: _____

THOUGHTS: Please check any of the following that apply to you:

___ I sometimes hear voices, even though no one nearby is talking to me
___ I sometimes wish I were dead
___ I sometimes want to kill myself
___ I sometimes feel that forces outside of me control me
___ I sometimes feel that other people control my thoughts
___ I sometimes have the same thought over and over and cannot control it
___ I sometimes feel that someone is out to hurt me or to do something against me
___ I sometimes am unable to control my behavior

Please list your Therapy Goals: _____

_____

_____

_____

_____

Client Signature: _____Date:_____