MAS Social Services Foundation

3820 Auburn Blvd, Suite 83
Sacramento, CA 95821
(916) 486-8626
ssf@mas-sac.org
www.mas-sac.org

Office use only

Assigned to……

Referred to ……..……..……

Assessment Form

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, then leave them blank and you will have a chance to complete them with your counselor. Records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name_____ Gender: F___ M___

Address_____ City_____ Zip_____

Age_____ E-mail (optional)_____

Phone_____ Can we leave a message at this number? Yes_____ No_____

Occupation _____ Employer _____

Emergency contact_____ Relationship _____

Phone_____

Preferred Language during counseling English____ Other _____

Counselor's gender preferences Male_____ Female_____ Either_____

Who do you live with?

Name	Age	Relationship to you	Supportive? Y / N
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION II: DESCRIPTION OF PROBLEM

Please tell us why you decided to come to the MAS Social Services Foundation:

_____

_____

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life").*

_____

How would you estimate the severity of the problem at this time? (Place "X" on the line below)

Mild Moderate Serious Severe

|_____|_____|_____|

In the past, what has been helpful to you in dealing with this problem? _____

_____

_____

Please tell us what you want to accomplish through counseling:

_____

_____

_____

SECTION III: MEDICAL HISTORY

Name and location of Physician_____

Date of your last physical exam: _____

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations).

Dates Problem & Treatment Were you hospitalized (Y/N)

_____

_____

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor, for past or current issues?

Yes ___ No ___

Problem Where Therapist When? Helpful? (Y/N)

_____

_____

_____

Have you ever been given a mental health diagnosis in the past from a mental health professional? Yes____ No____

If yes, as you understand it, what is/was that diagnosis? _____

SECTION IV: MEDICATIONS USED

If applicable, please list all medications you are now taking or have taken in the past three months, **vitamins, herbs and supplements**.

Medication Dosage Person prescribing How long have you been taking this? Helpful (Y/N)

_____

_____

SECTION V: FAMILY OF ORIGIN INFORMATION

	Name	Age	Occupation	Deceased (Y/N)
Parent/Guardian	_____	____	_____	_____
Parent/Guardian	_____	____	_____	_____
Siblings	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____

If applicable:			Living with you? (Y/N/Part time)	
Children	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____

Other relatives _____

Are your parents divorced? Yes _____ No _____

Have any members of your family had any serious health problems?
drugs ___ alcohol ___ depression ___ anxiety ___ other mental illness ___ diabetes ___ epilepsy ___

If so, who?_____

Are you: Single ___ Married ___ Divorced ___ Widowed ___ Engaged____

If applicable, describe your relationship with your spouse (place an X on the line below).

Major Problems Minor problems Satisfactory Very satisfactory
| _____ | _____ | _____ |

How long have you been in the relationship? _____

MEDICAL INSURANCE INFORMATION:

Insurance information will be helpful for outside referrals:

Insurance Company _____

Is there anything else we need to know to assist you? Please use the space below or ask for an extra sheet of paper if needed.

_____

_____

_____

Signature_____ **Date** _____