

Women's Speciality Assessment

Date _____ Client Name _____ SS# _____
Age _____ Birthdate _____ Martial Status: Single/Married/Divorced/Widow

Family History:

Who were you raised by (check all that apply) Biological Mother Biological Father
 Stepmother Stepfather Other: _____

How many brothers and sisters do you have? _____ Brothers _____ Sisters
Is there a history of mental illness in your family? Yes No If yes, who and what kind of problems. _____

Is there a history of drug and /or alcohol problems in the family? Yes No If yes, what kind of substance _____

Is there a history of legal problems in the family? Yes No If yes, who and what kind of problems? _____

As a child or adolescent, were you sexually abused? Yes No

As a child or adolescent, were you physically abused? Yes No

As a child or adolescent, were you emotionally abused? Yes No

As a child or adolescent did you witness any violence in your home? Yes No If yes, what kind of violence _____

Which of the following describes the family in which you grew up? Check all that apply
 Warm and Loving Cold and unaffectionate Strict Rules and expectations Permissive
 Neglectful Abusive Stressed Poor Middle Class Upper Class

Marriage and Partnership

Present relationship: Never married Married/living together Separated Divorced
 Widowed Engaged Boyfriend Girlfriend No Significant Relationship

If married or cohabiting, how many years with current partner? _____

How would you rate your relationship with your current mate/significant other?
 Usually get along Always get along Never get along Rarely get along
 Sometimes get along

Has your mate ever been treatment for a mental health issue? Yes No

Has your mate ever been treated for a substance abuse issue? Yes No

How many children to do have? _____ What are their ages? _____

Previous relationships/Marriages

Dates _____ Description _____ Number of Children _____

Dates _____ Description _____ Number of Children _____

Dates _____ Description _____ Number of Children _____

Dates _____ Description _____ Number of Children _____

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Education History

What was the last grade you completed? _____

What kind of grades did you obtain in school? _____

How would describe your school experience _____

Employment History

Are you currently employed? ___Yes ___No

How many jobs have you had in your lifetime? _____ What is your occupation? _____

Have you ever been fired from a job? ___Yes ___No If yes, what was the reason you were fired? _____

Military History

Did you ever served in the U.S. Military? _____

If yes, what branch of the service? _____

Did you ever serve in a combat zone? _____

If yes, when and where? _____

What was your discharge status? _____

Medical History

Medical Primary Care Physican _____ Last Seen _____

Psychiatrist _____ Last Seen _____

What is your height? _____ What is your weight? _____

Has your weight changed over the last year? ___No ___Yes Lost _____ lbs Gained _____ lbs

Number of pregnancies _____ Number of births _____

Did you use alcohol during your pregnancy? ___No ___Yes If so how much? _____

Did you use drugs during your pregnancy? ___No ___Yes If yes, which ones and how much _____

Have you experienced any changes in your eating habits/appetite ___Yes ___No If yes, please describe _____

What, if any, medical issues do you have? _____

How do you rate your health? ___Poor ___Fair ___Average ___Good ___Excellent

Are you currently taking any medications? ___Yes ___No If yes, what medications _____

Do you have difficulty sleeping? _____

Do you have nightmares/night terrors? ___Yes ___No

Psychiatric History

Have you ever been hospitalized for psychiatric reason? ___Yes ___No

If yes, where and when: _____

Have you ever been in counseling before? ___Yes ___No

If yes, what type of and when: _____