



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: _____