MANDARIN COUNSELING AND WELLNESS CENTER

12058 San Jose Blvd. Suite 703 Jacksonville, Florida 32223 Phone: 904-264-0454 Fax: 904-260-0044

ASSESSMENT

NAME: _____ E-MAIL ADDRESS: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK : _____

HOW DID YOU HEAR OF THE GROUP? _____

WHAT DO YOU HOPE TO UNDERSTAND FROM ATTENDING THIS GROUP?

_____

MENTAL HEALTH HISTORY / CONCERNS:_____

_____

FAMILY HISTORY OF MENTAL HEALTH PROBLEMS/DRUG OR ALCOHOL USE? _____

_____

NAME OF THERAPIST/DOCTOR: _____

PHONE #: _____ ADDRESS: _____

CURRENT PHYSICAL PROBLEMS: _____

LIST ANY MEDICATIONS/DOSAGE/FREQUENCY: _____

RECENT HOSPITALIZATIONS_____

THOUGHTS OF SUICIDE? YES: _____ NO: _____ HOMOCIDE? YES: _____ NO: _____

ALCOHOL USE: YES:_____ NO: _____ NUMBER OF DRINKS: _____DAILY: _____WEEKLY: _____MONTHLY: _____

HAVE YOU TAKEN DRUGS, OTHER THAN PRESCRIBED BY YOUR DOCTOR, EITHER NOW OR IN THE PAST?

NAME OF DRUG(S)/AMOUNT/FREQUENCY_____

_____

DO YOU NEED ANY SPECIAL ACCOMODATIONS TO ATTEND THE GROUP? YES: _____ NO: _____

IF SO, WHAT ARE YOUR NEEDS?_____