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Adult Assessment Form

Name: _____ **Date:** _____

CURRENT SITUATION **(presenting problem(s), precipitant(s), recent major stresses or life changes)**

_____

_____

_____

_____

HEALTH AND WELLNESS HISTORY

Primary Care Physician: _____

Please describe what you do to relax or take care of yourself:_____

Do you exercise? □Yes □ No If yes, how many times per week?_____

Do you have any physical health problem(s)? □Yes □ No If yes, what condition(s)? _____

_____ _____

_____ _____

Have you experienced any sleep disturbance in the past month?

□Yes □ No Comments: _____

Are you **currently** on any prescriptions, "over the counter" vitamins, herbs, supplements for anxiety, depression, mental health conditions or other medical conditions? □Yes □ No
If yes, list all medications:

Medication/Purpose: _____ _____

In the **past,** have you taken any medication for anxiety, depression or mental health condition? □ Yes □No

If yes, list all medications: _____ _____

BEHAVIORAL HEALTH **□Yes □No**

Have you had prior mental health services, counseling, or alcohol/drug treatment?

If Yes, please list names and dates below.

Out Patient		Inpatient	Date
Therapist or Program Name	Date	Hospital	

Regarding past or current treatment, what have you found most helpful? What has not been particularly helpful or effective? _____
_____

Have you ever experienced:

Physical abuse	□Yes □ No	Domestic violence	**□Yes □No**
Sexual abuse	□Yes □ No	Emotional abuse	**□Yes □No**
Rape/sexual assault	□Yes □No	Other significant trauma	**□Yes □No**

If Yes to any of the above explain:_____

Are you now or have you in the past experienced any suicidal feelings/behavior? □Yes □ No If yes, please describe._____
_____

Do you have any history of violent/aggressive behavior? □Yes □No If yes, please describe below

_____
_____

FAMILY/CURRENT LIVING SITUATION

List household members:

Name	Age	Relationship to client

Is there any history of emotional or mental problems in the family? □ Yes □ No

If Yes, explain:_____

_____

EMPLOYMENT

□ Full-time □Part-time □Unemployed Since _____ □Student

□ Homemaker □Volunteer □Retired Since _____ □Disabled Since_____

How long at current job?_____ How long at last job?_____

Are you having any problems at your workplace? □Yes □ No

If Yes, describe: _____

_____

ALCOHOL AND DRUG USEAGE

Do you smoke cigarettes or use tobacco in any other form? □Yes □ No

If yes, describe (how often, how much):_____

Do you drink alcohol? □Yes □ No

If yes, describe (how often, how much):_____

Have you ever had concerns about your use of alcohol, prescription medications, or other drugs? □Yes □ No

If yes, what were your concerns?_____

_____

Has anyone else expressed concerns about your use of alcohol, prescription medications or other drugs? □Yes □ No

If yes, who was concerned and what were their concerns?_____

_____

Have you ever made a decision to cut down or quit using alcohol and/or other drugs? □Yes □ No

If yes, what made you decide to cut down or quit and what was the outcome of your efforts to cut down or quit?

_____

Has anyone in your family ever had problems with alcohol or other drug use? □Yes □ No

If yes, describe:_____

Client's signature	Date
Reviewed/completed by Clinician	Date