

FRESH START COUNSELING SERVICES, LLC
ADULT ASSESSMENT

Name: _____
SSN/ID#: _____

CURRENT SITUATION (presenting problems, precipitating factors, recent major stressors or life changes)

What symptoms contributed to you coming in today? (Please check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> overeating | <input type="checkbox"/> restless | <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> compulsivity |
| <input type="checkbox"/> taking drugs | <input type="checkbox"/> depressed mood | <input type="checkbox"/> sweating | <input type="checkbox"/> impulsivity |
| <input type="checkbox"/> odd behavior/thoughts | <input type="checkbox"/> crying | <input type="checkbox"/> trembling or shaking | <input type="checkbox"/> fears/phobias |
| <input type="checkbox"/> recent weight gain | <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> recent weight loss | <input type="checkbox"/> low motivation | <input type="checkbox"/> muscle tension | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> recent appetite changes | <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> outbursts of temper | <input type="checkbox"/> distrust |
| <input type="checkbox"/> social withdrawal | <input type="checkbox"/> feelings of worthlessness | <input type="checkbox"/> nightmares | <input type="checkbox"/> jumpy |
| <input type="checkbox"/> family emotional problems | <input type="checkbox"/> stomach problems | <input type="checkbox"/> easily distracted | <input type="checkbox"/> dizzy or lightheaded |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> sleeping too much | <input type="checkbox"/> decreased need for sleep | <input type="checkbox"/> fatigue/no energy |
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> problems with school/wk | <input type="checkbox"/> housing problems | <input type="checkbox"/> obsessions |
| <input type="checkbox"/> difficulty staying asleep | <input type="checkbox"/> pain | <input type="checkbox"/> drinking alcohol | <input type="checkbox"/> relationship probs |
| <input type="checkbox"/> experienced traumatic event | <input type="checkbox"/> financial problems | <input type="checkbox"/> can't turn my mind off | <input type="checkbox"/> other: _____ |

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g. relationship ending, past trauma, etc.): _____

HEALTH AND WELLNESS HISTORY

Primary Care Physician: _____ Date of Last Visit to Physician: _____

Date of Last Physical: _____ Insurance: _____

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

Do you exercise? Yes No If yes, how many times per week? _____ Intensity? High Medium Low
Height _____ Weight _____ Do you have any drug/food allergies? Yes No If Yes, please specify: _____

Do you have any physical health problems? Yes No If Yes, what conditions? _____

How would you describe the nutritional value and balance of your diet: Excellent Good Fair Poor

Have you had significant appetite change over the past month? Yes No

Comments: _____

Have you had any weight change in the past 6 months? Yes No

Comments: _____

Have you experienced any sleep disturbance in the past month? Yes No

Comments: _____

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Are you **currently** on any prescriptions, "over the counter" vitamins, herbs, supplements for anxiety, depression, mental health conditions or other medical conditions?

Medication/Purpose: _____

In the **past**, have you taken any medication for anxiety, depression, or mental health condition? If yes, list all medications:

Are you having any problems or concerns with your sexual functioning? ___ Yes ___ No

Comments: _____

BEHAVIORAL HEALTH

Have you had prior mental health services, counseling, or alcohol/drug treatment? If yes, please list names and dates below.

Out Patient

Therapist or Program Name Date

Inpatient

Hospital Date

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, please 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: _____

Are you having any difficulty with any activities of daily living? ___ Yes ___ No

If yes, indicate with which activities you require assistance:

- | | | | |
|----------------------|----------------|--------------------|-----------------------|
| ___ Grooming/Hygiene | ___ Homemaking | ___ Mobility | ___ Leisure Skills |
| ___ Bathing | ___ Shopping | ___ Transportation | ___ Time Management |
| ___ Dressing | ___ Banking | ___ Communication | ___ Stress Management |
| ___ Cooking | ___ Budgeting | ___ Child Care | ___ Other _____ |

Describe any recent difficulties: _____

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CULTURAL/SEXUAL/SPIRITUAL

Cultural/ethnic/racial issues that need consideration? Yes No

If Yes, explain: _____

Sexual orientation issues that need consideration? Yes No

If Yes, explain: _____

Religious/spiritual issues that need consideration? Yes No

If Yes, explain: _____

FAMILY/CURRENT LIVING SITUATION

List Household Members:

Name	Age	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____

List children not residing in the home:

Name	Age	Living Arrangements
_____	_____	_____

Describe any concerns about family members: _____

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

If Yes, please explain: _____

MILITARY SERVICE Yes No

If Yes, Type of Discharge: _____

Were you involved in combat duty? Yes No

If Yes, please describe combat situation: _____

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: _____

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FINANCIAL

Are you having financial problems? _____ Yes ___ No

If Yes, please describe: _____

LEGAL

Have you ever had involvement with the legal system? _____ Yes ___ No

If Yes, explain when, what involvement, and the outcome: _____

Do you have any current pending legal charges? _____ Yes ___ No

If Yes, explain: _____

Are you on probation or parole? _____ Yes ___ No

If Yes, list PO's name and phone #: _____

Explain: _____

Have you ever been incarcerated (in jail)? _____ Yes ___ No

If Yes, explain: _____

ALCOHOL AND DRUG

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

If Yes, describe: _____

If applicable, amount of caffeinated beverages per day: coffee _____ soda _____ espresso _____ tea _____

Consider a typical week during the past month. Please fill in a number for each day of the week indicating the **typical number of drinks** you usually consume on that day and the **typical number of hours** you usually drink on that day.

1 Drink = 12 oz. beer /10 oz. microbrew/8 oz. malt liquor

4 oz. of wine

1 oz. of hard alcohol (regular shot glass)

	<u>Sunday</u>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>
# of Drinks							
# of Hours							

Think of the occasion that you drank the most in the past month. How much did you drink? _____ How many hours did you drink? _____ If applicable, other substances used: _____

Do you use alcohol or drugs to (check all that apply): Manage stress? ___ To relax? ___ Alter mood? ___ For sleep? ___

Have you ever had concerns about your use of alcohol, prescription medications or other drugs? ___ Yes ___ No If Yes, what were/are your concerns? _____

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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 on or quit using alcohol or other drugs? ___ Yes ___ No
If Yes, what made you decide to cut down or quit and what was the outcome of your effort to cut down or quit?

Have you ever experienced any of the following in connection with your use of alcohol or other drugs?

- | | | | |
|--------------------|----------------|-----------------------|----------------|
| Financial Problems | ___ Yes ___ No | Relationship Problems | ___ Yes ___ No |
| Work Problems | ___ Yes ___ No | Increased Tolerance | ___ Yes ___ No |
| Physical Problems | ___ Yes ___ No | Emotional Problems | ___ Yes ___ No |
| Blackouts | ___ Yes ___ No | Withdrawal | ___ Yes ___ No |
| Cravings | ___ Yes ___ No | Legal Problems | ___ Yes ___ No |

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

If Yes, describe: _____

How often do you gamble? (Please mark one response) ___ Never ___ Once a Year ___ 2-3 Times a Year ___ Every Other Month ___ Once a Month ___ 2-3 Times a Month ___ Weekly ___ More Than Once a Week ___ Every Other Day ___ Daily

Is there anything else that you feel is important to let your clinician know that has not been included in this assessment?

Client's Signature: _____ Date: _____

Reviewed/Completed by Clinician: _____ Date: _____

Reviewed/Updated by Clinician: _____ Date: _____