Alssaro Counseling Services, PLLC

Adult Self Assessment

Name: _____ Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

_____

_____

Please check all of the behaviors and symptoms that you consider problematic:

☐ Distractibiliy
☐ Hyperactivity
☐ Impulsivity
☐ Boredom
☐ Panic attacks
☐ Seasonal mood changes
☐ Sadness/depression
☐ Loss of pleasure/interest
☐ Hopelessness
☐ Thoughts of death
☐ Self-harm behaviors
☐ Crying spells
☐ Loneliness
☐ Low self worth
☐ Guilt/shame
☐ Fatigue
☐ Other: _____

☐ Change in appetite
☐ Racing thoughts
☐ Withdrawal from people
☐ Anxiety/worry
☐ Poor memory/confusion
☐ Nightmares
☐ Social discomfort
☐ Obsessive thoughts
☐ Compulsive behavior
☐ Aggression/fights
☐ Frequent arguments
☐ Irritability/anger
☐ Homicidal thoughts
☐ Flashbacks
☐ Hearing voices
☐ Visual hallucinations

☐ Suspicion/paranoia
☐ Lack of motivation
☐ Excessive Energy
☐ Wild mood swings
☐ Sleep problems
☐ Fear away from home
☐ Eating problems
☐ Gambling Problems
☐ Computer addiction
☐ Problems with pornography
☐ Parenting problems
☐ Sexual problems
☐ Relationship problems
☐ Work/school problems
☐ Alcohol/drug abuse
☐ Recurring, disturbing memories

Are your problems affecting any of the following?

☐ Handling everyday tasks ☐ Self-esteem ☐ Relationships ☐ Hygiene ☐ Work/school
☐ Housing ☐ Legal matters ☐ Finances ☐ Health ☐ Sexual activity
☐ Recreational activities

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☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself?
If yes, please describe:_____

_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else?
If yes, please describe:_____

_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else?
If yes, please describe:_____

_____

☐ Yes ☐ No Have you gambled in the past 6 months? If yes, let us know the following:

☐ Yes ☐ No Have you ever felt the need to bet more and more money?

☐ Yes ☐ No Have you ever had to lie to people about how much you have gambled?

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationships		Family Mental Health Problems	Who?
Mother					Hyperactivity	
Father					Sexually Abused	
Stepmother					Depression	
Stepfather					Manic Depression	
Siblings					Suicide	
					Anxiety	
					Panic Attacks	
					Obsessive-Compulsive	
Spouse/partner					Anger/Abusive	
Children					Schizophrenia	
					Eating Disorder	
					Alcohol Abuse	
					Drug Abuse	

☐ Parents legally married or living together

☐ Parents temporarily separated

☐ Parents divorced or permanently separated

☐ Mother remarried: _____ Number of times:____

☐ Father remarried: _____ Number of times:____

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Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse	☐ Neglect	☐ Lived in a foster home
☐ Sexual Abuse	☐ Violence in the home	☐ Multiple family moves
☐ Physical abuse	☐ Crime victim	☐ Homelessness
☐ Parent substance abuse	☐ Parent illness	☐ Loss of a loved one
☐ Teen pregnancy	☐ Placed a child for adoption	☐ Financial problems

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

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SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamine								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe:_____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? If yes, please describe:_____

_____

MEDICAL INFORMATION

Primary Care Physician:_____ Date of last physical exam:_____

Has you experienced any of the following medical conditions during your lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches

☐ Chronic pain ☐ Surgery ☐ Serious accident ☐ Head Injury

☐ Dizziness/fainting ☐ Meningitis ☐ Seizures ☐ Vision problems

☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Abortion

☐ Miscarriage ☐ Ear Infections ☐ Sleep disorder ☐ Sexually transmitted disease

☐ Other:_____

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Please list any CURRENT health concerns:_____

☐ Yes ☐ No Any current prescription medications? If yes, please list below:

Medication	Dosage	Date First Prescribed	Prescribed by

☐ Yes ☐ No Any current over-the counter medications (including vitamins, herbal remedies, etc.)? If yes, please list:_____

☐ Yes ☐ No Any allergies and/or adverse reactions to medications? If yes, please list:_____

_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends

☐ Students ☐ Co-workers ☐ Support/Self-Help Group

☐ Community Group ☐ Religious/Spiritual Center (If so, which one:_____)

To which cultural or ethnic group do you belong?_____

If you are experiencing any difficulties due to cultural or ethic issues, please describe:_____

_____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents:_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____

_____

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MISCELLANEOUS INFORMATION

Employment

Employer:_____

Position:_____ Length of time in this position:_____

Job Duties:_____

_____

Other jobs you have held:_____

Stress level of this position: ☐ Low ☐ Medium ☐ High

Education

☐ Yes ☐ No Are you currently attending school? If yes, which one?_____

☐ High school graduate or ☐ GED Year:_____

☐ Associate's Degree Year:_____ Major area of study:_____

☐ Undergraduate Degree Year:_____ Major area of study:_____

☐ Graduate Degree Year:_____ Major area of study:_____

Military Service

☐ Yes ☐ No Have you been/are you currently in the military? (If no, continue to the Legal section)

Branch_____ Date of Discharge_____

Type of Discharge_____ Rank_____

☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain:_____

_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain:_____

_____