

**Assessment - Adult Report**

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Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

<b>Client Name:</b> _____
<b>Chart No.</b> _____
<b>Date:</b> _____

**1. Why have you come to EAP (Presenting issue for Client)?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. How long has this been an issue?**

\_\_\_\_\_

**3. What have you tried to do to resolve this issue?**

\_\_\_\_\_  
\_\_\_\_\_

**4. What are your goals for counseling?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Previous Treatment History** ( Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems and chemical dependency/use. )

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. Has any member of your family, including grandparents, been diagnosed or had significant problems with mental health issues, alcohol use or chemical dependency? If so, please explain**

\_\_\_\_\_  
\_\_\_\_\_

<b>Client name:</b> _____
<b>Chart number:</b> _____
<b>Date:</b> _____

**7. Who resides with you in your home.**

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**8. Health** (describe your general health as well as any chronic conditions including pain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was your last complete physical exam by an M.D. \_\_\_\_\_

Are you currently under the care of an M.D. for any condition. Yes \_\_ No \_\_

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Please rate the nutritional value of your total daily diet intake. Good \_\_ Fair \_\_ Poor \_\_

If Fair or Poor, please explain : \_\_\_\_\_

Please check any of the following that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Significant weight gain/loss in the last six months | <input type="checkbox"/> Dieting                         |
| <input type="checkbox"/> Food/drug allergies                                 | <input type="checkbox"/> Overeating or eating too little |
| <input type="checkbox"/> Problems chewing or swallowing                      |  |

If any box is checked please explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any functional limitations that affect your daily living (e.g. physical impairments, problems with self care, speech, vision, or hearing)? Yes \_\_\_ No \_\_\_

If Yes please explain: \_\_\_\_\_

Client Name:	_____
Chart No.	_____
Date:	_____

**9. Please list all current medications including over the counter and prescription medications.**

Name of Medication	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**10. Please List prior medication for mental health issues, chemical dependency or alcohol use.**

Name of Medication	Dosage	Date Started	Date Discontinued
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**11. Legal History**

Please place an **N** for none, **C** for currently experiencing or **P** for experienced in the past.

DUI _____	Bankruptcy _____	Divorce _____
Unemployment _____	Domestic Violence _____	Custody Dispute _____
Disability Claim _____	Workman's compensation _____	

**12. Financial Problems:**

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**13. Educational Background:**

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**14. Employment History** (Please describe current job briefly):

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**15. Military Service:**

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Client name: \_\_\_\_\_  
Chart number: \_\_\_\_\_  
Date: \_\_\_\_\_

### 16. History of Abuse

Please place an **N** for none, **C** for currently experiencing or a **P** for experienced in the past.

Verbal Abuse \_\_\_\_\_ Emotional Abuse \_\_\_\_\_ Childhood Abuse \_\_\_\_\_  
Physical Abuse \_\_\_\_\_ Spouse Abuse \_\_\_\_\_  
Sexual Abuse \_\_\_\_\_ Elder Abuse \_\_\_\_\_

### 17. Alcohol and Drug Use

Do you drink alcohol? Yes \_\_\_ No \_\_\_ If Yes, how often: \_\_\_\_\_

When was the last time you had a drink? \_\_\_\_\_

How much did you drink at that time? \_\_\_\_\_

Do you have any history of using non-prescribed drugs or abusing prescribed medications? Yes \_\_\_ No \_\_\_

Do you currently use any non-prescribed drug or abuse a prescribed medication? Yes \_\_\_ No \_\_\_

What substances have you used in the last 6 months? (Check all that apply.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Marijuana / "Pot" | <input type="checkbox"/> Cocaine                | <input type="checkbox"/> Inhalants / "Huffing" |
| <input type="checkbox"/> LSD / "Acid"      | <input type="checkbox"/> Amphetamines / "Speed" | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Pain Killers      | <input type="checkbox"/> Sedatives / "Downers"  | <input type="checkbox"/> None of Above         |

If 'Other' is checked, explain below.

Check any of the following that has occurred as a result of your drinking or drug use.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arrest              | <input type="checkbox"/> DUI                | <input type="checkbox"/> Family Problems       |
| <input type="checkbox"/> Public Intoxication | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Arguments             |
| <input type="checkbox"/> Work Problems       | <input type="checkbox"/> Health Problems    | <input type="checkbox"/> Relationship Problems |

### 18. Sexual/Affectional History

Are you satisfied with your sex life? \_\_\_ yes \_\_\_ no

Do you have any concerns or questions about your sexual orientation or experiences? (If so, please explain.)

### 19. Religious/Spiritual History

Do you feel you have any concerns or problems with your religion and/or spiritual beliefs? Please describe.

### 20. History of Harm to Self or Others

Do you currently have any urges/thoughts of hurting yourself? Yes \_\_\_ No \_\_\_

Any current urges/thoughts of hurting another? Yes \_\_\_ No \_\_\_

Any history of hurting self or suicide attempt? Yes \_\_\_ No \_\_\_

Any history of physical aggression toward another? Yes \_\_\_ No \_\_\_

If Yes on any question, please describe. \_\_\_\_\_

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### SYMPTOM CHECK LIST:

Revised 01/03 - 4 -

Client Name: \_\_\_\_\_  
Chart No. \_\_\_\_\_  
Date: \_\_\_\_\_

- 0) None:
- 1) Mild: Some Times/Some Concern/Brief Episode
- 2) Moderate: Often/Significant Worry/Lasts for a While
- 3) Severe: Very Often/High Intensity/Continuous

<b>MOOD</b>	
Loss of energy / fatigue	
Appetite Change (more or less)	
Social Withdrawal	
Crying	
Sleep Problems (more) (less)	
Feeling Hopeless	
Negative Thinking	
Depressed / Sad	
Self-Esteem Issues	
Concentration Trouble	
Blaming Self	
Blaming Others	
Dislike Being Touched	
Mood Swings	
Decreased Sex Drive	
Decreased Desire for Fun	
Social Embarrassment	
Panic Attacks	
Repeated Actions	
Repeated Thoughts	
Anxiousness /Anxiety	
Fears / Phobias	
<b>Work/School Issues</b>	
Absenteeism/Tardy	
Difficulty Holding a Job	
Poor Attitude	
Termination/Expelled	

Stress on Job/School	
<b>BEHAVIOR</b>	
Irritable	
Verbally Argumentative	
Physically Aggressive	
Throws Things	
Slams Doors	
Hits/hurts self	
Inattentive	
Impulsive	
Hyperactive	
Defiant / Stubborn	
Lies	
Stealing	
Overspending Issues	
Damages property	
<b>RELATIONSHIPS</b>	
Issues with Spouse/ Significant Other	
Issues with Children	
Issues with Parents	
Issues with Employer/Boss	
Issues with Co-workers	
Issues with Peers/Friends	
Grief/Loss Issues	
Trust Issues	
Issues with Teacher (School)	
<b>SUBSTANCE ABUSE</b>	

Alcohol Use	
Prescription Drug Use	
Non-Prescription Drug Use	
Loss of Control Over Use	
Cravings for Drugs/Alcohol	
Potential for Withdrawal from D/A	
Personality Changes When Using	
Blackouts from Drug/Alcohol Use	
<b>THOUGHT PROCESSES</b>	
Bizarre/Confused Thinking	
Believe Unusual Thoughts	
Hallucinations	
Disorganized Speech	
Suspicious	
Unaware of Time	
Unaware of Self	
Unaware of Surroundings	
Disorganized Behavior	
Thoughts of Hurting Self	
Thoughts of Hurting Others	

Other: \_\_\_\_\_