

Assessment - Couples Report

Date of Birth: _____ Age: _____

Client Name: _____
Chart No. _____
Date: _____

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

Client name: _____
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Date: _____

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

13. Educational Background

14. Employment History (Please describe current job briefly)

15. Military Service:

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. _____

Assessment - Couples Report

SYMPTOM CHECK LIST:

- 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

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MOOD	
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	
Work/School Issues	
Absenteeism/Tardy	
Difficulty Holding a Job	
Poor Attitude	

Termination/Expelled	
Stress on Job/School	
BEHAVIOR	
Irritable	
Verbally Argumentative	
Physically Aggressive	
Throws Things	
Slams Doors	
Hits/hurts self	
Inattentive	
Impulsive	
Hyperactive	
Defiant / Stubborn	
Lies	
Stealing	
Overspending Issues	
Damages property	
RELATIONSHIPS	
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)	
SUBSTANCE ABUSE	
Alcohol Use	
Prescription Drug Use	
Non-Prescription Drug Use	
Loss of Control Over Drug/Alcohol Amounts Used	
Cravings for Drugs/Alcohol	
Potential for Withdrawal from Drugs/Alcohol	
Personality Changes When Using Drugs/Alcohol	
Blackouts from Drug/Alcohol Use	
THOUGHT PROCESSES	
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: _____

Couples Questionnaire

Client Name: _____

Chart No. _____

Date: _____

- 0) Never
- 1) Sometimes
- 2) Often
- 3) Very Often

(Circle an Option)

1. When I have a decision to make, I include my partner.	0	1	2	3
2. I believe my partner could do much more for me if they wanted to.	0	1	2	3
3. I need to have one person who puts above all others.	0	1	2	3
4. I fear I will lose the love and support of my partner.	0	1	2	3
5. The best way to get my partner to something for me is to ask.	0	1	2	3
6. I use pressure to get what I want.	0	1	2	3
7. I prefer avoiding arguments.	0	1	2	3
8. I get unpleasant feelings when I realize I am about to get into an argument.	0	1	2	3
9. I need to be committed to someone to have sex with that person.	0	1	2	3
10. It is possible to enjoy sex with a person and not like that person very much.	0	1	2	3
11. Being friends with my partner is important.	0	1	2	3
12. My partner meets my needs.	0	1	2	3
13. My marital relationship is my most important relationship.	0	1	2	3
14. Having a satisfying relationship is more important to me than my partner.	0	1	2	3
15. My partner and I work together to find solutions to our problems.	0	1	2	3
16. My partner and I enjoy spending time with one another.	0	1	2	3
17. My partner values my opinion.	0	1	2	3
18. I value my partner's opinion.	0	1	2	3
19. I am satisfied with my relationship with my partner.	0	1	2	3

Name of Person Filling Out Form: _____