

CONCERN[®] SERVICES
ADULT ASSESSMENT

Name: _____
SS#/ID#: _____
DOB: _____

Please fill out each page (including name, S.S.# and DOB) of the assessment form in blue ink.

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

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 problem(s)? Yes No If yes, what condition(s)? _____

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 If yes, amount +/- _____

Comments: _____

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: _____

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

Comments: _____

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BEHAVIORAL HEALTH

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Have you had prior mental health services, counseling, or alcohol/drug treatment? Yes No

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Domestic violence | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sexual abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rape/sexual assault | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other significant trauma | <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

If yes, indicate with which activities the client requires assistance from another person:

- | | | | |
|-------------------------------------------|-------------------------------------|-----------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Grooming/Hygiene | <input type="checkbox"/> Homemaking | <input type="checkbox"/> Mobility | <input type="checkbox"/> Leisure Skills |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Shopping | <input type="checkbox"/> Transportation | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Banking | <input type="checkbox"/> Communication | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Budgeting | <input type="checkbox"/> Child Care | <input type="checkbox"/> Other _____ |

Describe any recent difficulties: _____

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CULTURAL/ETHNIC/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

Name	Age	Relationship to client

List children not residing in the home:

Name

Age

Living Arrangements

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: _____

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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: _____

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: _____

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ALCOHOL AND DRUG

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

If yes, describe: _____

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 drug? 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 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, prescription medications, or other drugs?

- | | | | |
|----------------------------------------------------------|--------------------|----------------------------------------------------------|-----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Financial Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Work problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Increased Tolerance |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Blackouts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Withdrawal Symptoms |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cravings | <input type="checkbox"/> Yes <input type="checkbox"/> No | Legal |

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 _____

Reviewed/Updated by Clinician _____ Date _____