The Counseling and Cooperative Parenting Center of Ohio, LLC
CCPC·OHIO
8559 S. Mason Montgomery Rd, Mason, OH 45040
P: 513-229-8980 F: 513-229-8935 ccpc-ohio.com

ADULT ASSESSMENT FORM

Date: _____

Client Name: _____ **Date of Birth:** _____

CURRENT SITUATION:

What concern brings you here: (How long has this been a problem?)
(What have you done, or are you doing, to resolve this problem?)

_____
_____
_____
_____

What do you hope to accomplish in this session/in therapy?

_____
_____

Any deterioration in job / school performance as a result of the problem**?**

☐ Attendance ☐ Absences Mon/Fri.'s ☐ Tardiness ☐ Decrease in productivity
☐ Erratic Behavior ☐ Conflict with supervisor ☐ Discipline ☐ None
☐ Promises to Improve ☐ Accidents/safety violations ☐ Conflicts with fellow employees

On a Scale of 1-5, how would you rate your distress? (l is low, 5 is severe distress) _____

SIGNIFICANT EVENTS:

☐ Change of job ☐ Move to a new place
☐ Death in family ☐ Serious illness or injury to family member/friend
☐ Divorce or separation ☐ Other
☐ Frightening experience ☐ None of the above
☐ Loss of someone close to you

Comments:

_____
_____

HEALTH HISTORY:

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):

_____

_____

Tobacco products use - ☐ Current ☐ Past ☐ Never Used

Packs per day _____ Other Tobacco Product Use: _____

Weight change in the past 6 months: ☐ Yes ☐ No Amount: _____

Significant appetite change over the past month: ☐ Yes ☐No

Are you currently on any physician-prescribed medications or regularly take any "over the counter" medication, including any prescriptions for anxiety, depression or other mental conditions? ☐ Yes ☐ No

If yes, please list all medications below:

Medication/Purpose	**Dosage/Times Per Day**	**How Long?**	**Prescribed by**

In the past, have you taken medication for a mental health condition? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Have you had prior major medical/surgical treatments? ☐ Yes ☐ No

If yes, please list treatments and dates below:

Date	**Medical & Surgical**	**Provider/Program/Hospital**

Health Habits Information:

For the following questions please base your answers on **the past month** (approximately).

☐Y ☐N 1. Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
☐Y ☐N 2. Have you been dieting to lose weight?
☐Y ☐N 3. Have you smoked cigarettes?
☐Y ☐N 4. Have you experienced any increased feelings of sadness or hopelessness?
☐Y ☐N 5. Have you felt more anxious or worried than usual?
☐Y ☐N 6. In the past **month** have you used any illicit or non-prescription drugs?
☐Y ☐N 7. During the past **month** have you participated in leisure/social/spiritual activities?

BEHAVIORAL HEALTH:

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

If yes, please list names and dates below:

Date	Psychiatric	Provider/Program/Hospital
Date	**Chemical Dependency**	**Provider/Program/Hospital**

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

If yes, please explain_____

_____

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

If yes, please explain_____

_____

_____

Have you ever experienced:

□ Physical abuse □ Rape/sexual assault □ Emotional abuse

□ Sexual abuse □ Domestic violence □ Other significant trauma

Please comment:

_____

_____

_____

FAMILY HISTORY:

List all the people who are currently living in the household:

Name Age Relationship to Client

_____

_____

_____

_____

_____

_____

EMPLOYMENT:

Are you currently employed outside the home? □ Yes □ No

If yes, what position do you hold and how long have you been at this particular job?_____

_____

_____

LEGAL:

Have you been involved in any legal matters in the past/present? □ Yes □ No

If yes, please explain_____

_____

_____

CULTURAL/ETHNIC/SEXUAL/SPIRITUAL:

Cultural/ethnic/racial issues that need consideration:_____

_____

_____

Sexual orientation issues that need consideration:_____

_____

_____

Religious/spiritual issues that need consideration:_____

_____

_____

_____ _____

Client Signature Date

_____ _____

Signature of CCPC-Ohio Therapist Date

_____ _____

Reviewed/Updated Date