Dr. Sharon Phillips, LLC
9078 Union Centre Blvd., Suite 350
West Chester, OH 45069
(513) 785-0831

ADULT ASSESSMENT (Rev. 4/19)

Name: _____ Date of Birth: _____

Date: _____

CURRENT SITUATION:

Briefly describe your reason for seeking help: _____

_____

_____

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

_____

_____

HEALTH HISTORY:

Do you have any drug/food allergies? _____ yes _____ no If yes, please specify:

_____

When were you last examined by a physician? _____

List any major health problems for which you are currently receiving treatment: _____

_____

_____

Tobacco products use- _____current _____past _____ never used
Packs per day _____ Other tobacco product use: _____

Dr. Sharon Phillips, LLC
9078 Union Centre Blvd., Suite 350
West Chester, OH 45069
(513) 785-0831

ADULT ASSESSMENT (Rev. 4/19)

Name: _____ Date of Birth: _____

Weight change in the past 6 months: _____ yes _____ no Amount: + _____ or - _____

Significant appetite change over the past month: _____ yes _____ no

How do you feel about your body? _____

Do you have any sleep difficulties? _____ yes _____ no

Comment: _____

Are you currently on any prescription medication or regularly take any "over the counter" medication, including any prescriptions for anxiety, depression, or other mental health conditions? _____ yes _____ no

If yes, please list all medications below:

Medication/purpose	Dosage/times per day	For how long?	Do you take it consistently?

In the past, have you taken medication for a mental health condition? _____ yes _____ no

If yes, please describe: _____

Dr. Sharon Phillips, LLC
9078 Union Centre Blvd., Suite 350
West Chester, OH 45069
(513) 785-0831

ADULT ASSESSMENT (Rev. 4/19)

Name: _____ Date of Birth: _____

Have you had prior mental health services, counseling, or alcohol/drug treatment? _____ yes _____ no

If yes, please list names and dates below:

OUTPATIENT		**INPATIENT**	
THERAPIST OR PROGRAM NAME	DATE	HOSPITAL	DATE

Is there any history of emotional or mental problems in your family of origin? _____ yes _____ no

If yes, please explain: _____

_____

Has anyone in your family of origin 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

Dr. Sharon Phillips, LLC
9078 Union Centre Blvd., Suite 350
West Chester, OH 45069
(513) 785-0831

ADULT ASSESSMENT (Rev. 4/19)

Name: _____ Date of Birth: _____

Please comment: _____

_____

_____

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: _____

Dr. Sharon Phillips, LLC
9078 Union Centre Blvd., Suite 350
West Chester, OH 45069
(513) 785-0831

ADULT ASSESSMENT (Rev. 4/19)

Name: _____ Date of Birth: _____

CURRENT LIVING ARRANGEMENTS:

Are you _____ married _____ single _____ divorced _____ widowed _____living with someone?

Who lives in your home?

NAME	AGE	RELATIONSHIP

Please add any additional information which you feel may be useful:

_____

_____

_____

_____

Client Signature _____ Date _____

Reviewed by Dr. Sharon Phillips _____ Date _____