

Dr. Sharon M. Phillips & Associates, LLC  
8050 Beckett Center Drive, Suite 216  
West Chester, OH 45069  
(513) 860-0801

ADULT ASSESSMENT (Rev. 2/12)  
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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: \_\_\_\_\_

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Weight change in the past 6 months: \_\_\_\_\_ yes \_\_\_\_\_ no Amount: \_\_\_\_\_

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: \_\_\_\_\_

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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:

<b>OUTPATIENT</b>		<b>INPATIENT</b>	
<b>THERAPIST OR PROGRAM NAME</b>	<b>DATE</b>	<b>HOSPITAL</b>	<b>DATE</b>

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

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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: \_\_\_\_\_

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**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:

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Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by Clinician \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by Clinician \_\_\_\_\_

Date \_\_\_\_\_