Change for Living
COUNSELING, PLLC

CONFIDENTIAL ADULT SELF-EVALUATION

Name:_____ Date:_____

Current Concerns *(What are the main reasons you are seeking help?)*

	Primary Issue	Important Issue
Personal/Emotional Issues	☐	☐
Relationship/Marital	☐	☐
Job/Career	☐	☐
Family of Origin Issues	☐	☐
Child/Parenting Concerns	☐	☐
Financial Issues	☐	☐
Health Problems	☐	☐
Other Life Stressors	☐	☐

Other:_____

_____

How long have you been experiencing these problems?_____

What have you done to address these problems?_____

_____

_____

What do you think is causing these problems?_____

_____

_____

Have you experienced any major life changes in the past few months?_____

_____

Who lives in your household?

Name	Age	Relationship to You

Significant life trauma(s)/losses:

Trauma/Loss	When

Any history of suicidality/homicidality?

Suicide attempt(s)? □Yes □No How/when?_____

Current suicidal thoughts? □Yes □No Plan?_____

Homicidal/violent thoughts/plans? □Yes □No Describe_____

Substance Use History

Alcohol Use:

Frequency of use:	□None	□Monthly	□Weekly	□Daily
How much:	□None	□1-2	□3-5	□More than 5
Drink of choice:	□Beer	□Wine	□Hard Liquor	
Do you think it's a problem?	□Yes	□No	□Unsure	

Other Drug Use:

Marijuana: □None □Occasionally □Weekly □Daily

Other non-prescription substances:

□None □Occasionally □Weekly □Daily

If yes, list what substances_____

Prescription drugs used <u>not</u> as prescribed:

□None □Occasionally □Weekly □Daily

If yes, what prescriptions_____

Work History

Current employment status:

□Employed, full-time
□Employed, part-time
□Self employed
□Retired
□Unemployed
□Student
□Homemaker/stay at home parent
□Other(specify)_____

Job satisfaction:

□Very satisfied □Moderately satisfied □Not satisfied at all

Treatment History

List hospitalizations for medical, psychiatric or chemical dependency problems.

Date(s)	Reason	Hospital

Previous or current therapy, counseling, EAP or substance abuse treatment:

□Individual therapy □Marital/couples therapy
□Group therapy □12-step program
□Medication management/psychiatrist
□Pastoral/religious

Provider	When	Reason sought treatment

Child and Family History

Is there a family history of any of these issues? (check all that apply)

□Substance Abuse □Mental Illness □Suicide

Name	Relationship to You	Problem

Did you experience any of the following as a child/young adult?

School problems: □Yes □No Age_____
Depression: □Yes □No Age_____
Substance abuse: □Yes □No Age_____
Legal problems: □Yes □No Age_____
Sexual or physical abuse: □Yes □No Age_____
Domestic violence: □Yes □No Age_____

Did you experience any other major childhood issues? □Yes □No
Describe_____

Growing up were your parents?
□Together/Married Age_____
□Divorced/Separated Age_____
□Deceased Age_____

Siblings?

Name	Age	Biological, ½ sibling, step, adopted?

Symptom Checklist

Please check (☑) near all that apply to how you have been feeling.

	Sleep problems		Memory problems		Hard time sitting still/restless
	Not enjoying things		Loss of time		Worrying a lot
	Problems at work		Racing heart		Drug/alcohol use
	Perseverating/obsessive thoughts		Nervous or tense/unable to relax		Concerns about sexual feelings or identity
	Lack of friends		Relationship problems		Other sexual concerns
	Stomach aches/digestive problems		Shy/uncomfortable around others		Not feeling confident
	Feeling panic or fear		Problems concentrating		Racing thoughts
	Feeling anxious		Grief or loss		Problem eating habits
	Not feeling good enough		Feeling hopeless		Feeling worthless
	Compulsive behaviors		Disturbing thoughts		Not getting along with others
	Wanting to hurt self		Mood swings		Shaking/trembling
	Wanting to harm others		Feelings of wanting to die		Chronic pain
	Aggressive/abusive		Sadness or depression		Childhood issues
	Angry easily or a lot		Confused thinking		Problem staying on task
	Problems with sexual thoughts/ behavior		Problems with decision making/judgement		Concerns about family members
	Irritable		Abused by others		Illegal behavior
	Isolating/not wanting to be around others		Do things without thinking/ impulsive		See or hear things others don't
	Self harm behaviors		Disorganized thoughts		Weight concerns
	Concerns about gender		Feeling helpless		Other addictive behavior

Please write down any other information that would be helpful for me to know about the problems or situation.

_____

_____

_____

_____

_____

What do you want to accomplish in treatment/What goals do you have?

_____

_____

_____

_____

_____

_____