Central Ohio Counseling

Adult Self-Assessment

Name_____ Date of Birth_____

Briefly describe the issues/problems for which you are seeking help:

Have you ever been in treatment before? ☐yes ☐no

Type of treatment received: ☐counseling ☐medication management

☐Intensive outpatient program ☐hospitalization

Treatment dates:

If so, name/address/phone of therapist/psychiatrist/facility:

Have you ever been diagnosed with a mental illness? If so, please list:

When was your last physical examination?

Do you currently have any medical issues? ☐yes ☐no

If so, please list:

Do you have any allergies or allergies to medication? ☐yes ☐no

If so, please list:

Have you ever had issues with the following:

Psych: ☐ Depression ☐ Anxiety ☐ Mood Swings ☐ Substance Abuse ☐ Anger/Rage (mild)	
☐ Impaired Concentration ☐ Grandiosity ☐ Hallucinations ☐ Delusions	
Neuro: ☐ Headache ☐ Tremor ☐ Seizures ☐ Vertigo (rarely)	
Eyes: ☐ Blurred Vision ☐ Light Sensitivity ☐ Focus Problems	
Cons: ☐ Fatigue ☐ Drowsiness ☐ Sleep Change ☐ Appetite Change	
GU: ☐ Urinary Dysuria ☐ Frequent Urination ☐ Urgency	
Endo: ☐ Goiter ☐ Salt Craving ☐ Increased Thirst	
Cardio/respiratory: ☐ Palpitations ☐ Edema ☐ Chest Pain ☐ Dyspnea ☐ Cough	
GI: ☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Constipation ☐ Abdominal Pain ☐ Cramping	
Motor: ☐ Restless Leg ☐ Gait ☐ Shuffling	☐ Dry Mouth ☐ Skin Rash/ Dryness

Are you currently taking any prescription medications? ☐yes ☐no

If yes, please list:

Medication	Dosage	Frequency	Prescribing MD

Have you experienced weight gain in the last year? ☐yes ☐no _____lbs

Have you experienced weight loss in the last year? ☐yes ☐no _____lbs

Sleep health, do you experience any of the following:

☐trouble falling/staying asleep ☐inability to “switch off” mind

☐excessive wakefulness ☐excessive daytime sleepiness

Average number of hours you sleep a night? _____

Are you experiencing any issues with interpersonal relationships? If so, please list:

Substance use/abuse:

☐past ☐current

Substance	Frequency	Past/Present

Do you have other family members that have substance use/abuse issues?

☐yes ☐no

Do you have other family members that have been diagnosed with a mental illness?

☐yes ☐no If so, please list:

What is your educational background?

☐high school diploma ☐some college ☐college graduate

Have you served in the military? ☐yes ☐no

What statement best describes your financial situation?_____

What statement best describes your legal situation?_____

Below you will find a list of problems which people commonly face. First, read the list carefully and make a check mark next to each problem that you are now having. Second, circle those problems which you believe are the worst or which are causing you the most trouble at this time. Remember, there are no correct or incorrect answers.

- ☐ aggression
- ☐ alcohol dependence
- ☐ anger
- ☐ anxiety
- ☐ avoiding people
- ☐ concentration problems
- ☐ chest pain
- ☐ depression
- ☐ disorientation
- ☐ dizziness
- ☐ disorganized thoughts
- ☐ drug dependence
- ☐ eating disorder
- ☐ fatigue
- ☐ guilt
- ☐ hallucinations
- ☐ heart palpitations
- ☐ irritability
- ☐ isolation
- ☐ insomnia/sleep problems
- ☐ judgement errors
- ☐ loneliness
- ☐ memory impairment
- ☐ mood swings
- ☐ panic attacks
- ☐ not getting along with people
- ☐ financial problems
- ☐ feeling unattractive
- ☐ feeling unpopular
- ☐ job/vocational problems
- ☐ feeling out of control
- ☐ marital problems
- ☐ problems with children
- ☐ medical/health problems
- ☐ health problems of family member
- ☐ feeling abandoned
- ☐ unable to work out religious beliefs
- ☐ legal problems
- ☐ fear of going crazy
- ☐ feeling hopeless
- ☐ feeling like a failure
- ☐ feeling uncared for
- ☐ feelings of being misunderstood
- ☐ feeling unconnected to people
- ☐ sleeping excessively
- ☐ afraid of hurting self
- ☐ afraid of hurting others
- ☐ losing track of time
- ☐ getting too emotional
- ☐ restricting activities

- ☐ paranoid thoughts
- ☐ perfectionism
- ☐ phobias/irrational fears
- ☐ preoccupation with problems
- ☐ sadness
- ☐ sexual difficulties
- ☐ stress/tension
- ☐ suicidal thoughts
- ☐ social withdrawal
- ☐ temper outbursts
- ☐ tearfulness
- ☐ worry
- ☐ feeling attacked
- ☐ following irrational rituals
- ☐ lack of sexual desire
- ☐ feeling unhappy all the time
- ☐ feeling afraid of many things
- ☐ problems with sexual identity
- ☐ having a physical disability
- ☐ being overly influenced by others
- ☐ unable to stop worrying
- ☐ no time for leisure activities
- ☐ no friends
- ☐ no interest in anything

Adult ADHD Self-Report Scale v1.1 (ASRS)

Instructions:

Please answer the questions below, rating yourself on each of the criteria shown. As you answer each question, select the box that best describes how you have felt and conducted yourself over the past 6 months.

	PART A - How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	0	1	1	1
2	How often do you have difficulty getting things in order when you have to do a task that requires organisation?	0	0	1	1	1
3	How often do you have problems remembering appointments or obligations?	0	0	1	1	1
4	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	0	0	1	1
5	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	0	0	1	1
6	How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	0	0	1	1
	PART B - How often do you make careless mistakes when you have to work on a boring or difficult project?	0	0	0	1	1
8	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	0	0	1	1
9	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	0	1	1	1
10	How often do you misplace or have difficulty finding things at home or at work?	0	0	0	1	1
11	How often are you distracted by activity or noise around you?	0	0	0	1	1
12	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	0	1	1	1
13	How often do you feel restless or fidgety?	0	0	0	1	1
14	How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	0	0	1	1
15	How often do you find yourself talking too much when you are in social situations?	0	0	0	1	1
16	When youìre in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	0	0	1	1	1
17		0	0	0	1	1
18	How often do you have difficulty waiting your turn in situations when turn taking is required?					
	How often do you interrupt others when they are busy?	0	0	1	1	1