JEROME O. MILLS, LCSW
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ASSESSMENT

Please complete this form to the best of your ability.

Primary Client Name: Spouse/Partner Name:
Last First

Family Members in Household (Name)	Relationship	Date of Birth (Age)

What counseling or treatment have you had before.

Was it helpful ?

OVERALL HOW SERIOUS IS THIS PROBLEM ?	Not Very Serious				Very Serious
HOW HAS THIS PROBLEM AFECTED:	(Mild)		(Moderate)		(Severe)
Marriage/Partner ?	1	2	3	4	5
Family ?	1	2	3	4	5
Job/School Performance ?	1	2	3	4	5
Friendships ?	1	2	3	4	5
Financial Situation ?	1	2	3	4	5
Legal Situation ?	1	2	3	4	5
Health ?	1	2	3	4	5
Anxiety Level/Nerves ?	1	2	3	4	5
Mood ?	1	2	3	4	5
Eating Habits ?	1	2	3	4	5
Sleeping Habits ?	1	2	3	4	5
Ability to Concentrate ?	1	2	3	4	5
Ability to Control Temper ?	1	2	3	4	5

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Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected by each by circling the appropriate number. Please circle one number for every item.

Not a Problem	A Slight Problem	A Moderate Problem	A Serious Problem	A Severe Problem
1	2	3	4	5

I. YOUR PHYSICAL FUNCTIONS		III. YOUR BEHAVIOR CON'T	
01. Sleep Pattern	1 2 3 4 5	21. Lying	1 2 3 4 5
02. Eating Pattern	1 2 3 4 5	22. Stealing	1 2 3 4 5
03. Bladder Control	1 2 3 4 5	**23.** Withdrawal from Others Socially	1 2 3 4 5
04. Bowel Control	1 2 3 4 5	**24.** Dependency (relying on others to make your Decisions and take care of you.)	1 2 3 4 5
05. Seizures or Convulsions	1 2 3 4 5	25. Suspiciousness (questions other peoples motives)	1 2 3 4 5
06. Weight Problem	1 2 3 4 5	26. Hostility (feeling angry towards others)	1 2 3 4 5
07. Sexual Functioning	1 2 3 4 5		
II. YOUR EXPERIENCE AT WORK		IV. YOUR FEELINGS & MOODS	
08. General Performance	1 2 3 4 5	27. Depression (sadness)	1 2 3 4 5
09. General Satisfaction	1 2 3 4 5	28. Euphoria (feeling high)	1 2 3 4 5
10. Lateness	1 2 3 4 5	29. Sudden Changes in Mood for No Apparent Reason	1 2 3 4 5
11. Absenteeism	1 2 3 4 5	30. Anxiety (Nervousness)	1 2 3 4 5
12. Negative Feelings About Work	1 2 3 4 5	31. Lack of Energy	1 2 3 4 5
13. Relating to Supervisors	1 2 3 4 5	32. Feeling Angry	1 2 3 4 5
14. Relating to Co-Workers	1 2 3 4 5	33. Not Liking Self	1 2 3 4 5
		34. Not Liking Others	1 2 3 4 5
III. YOUR BEHAVIOR		**V. YOUR INNER THOUGHTS & IDEAS**	
15. Difficulty with Daily Routine	1 2 3 4 5	35. Thoughts About Hurting Yourself	1 2 3 4 5
16. Letting Others Take Advantage of You	1 2 3 4 5	36. Thoughts About Hurting Others	1 2 3 4 5
17. Hyperactivity	1 2 3 4 5	37. Having Unwanted Thoughts Again & Again	1 2 3 4 5
18. Repeating Certain Acts Again and Again	1 2 3 4 5	38. Worrying About Your Health	1 2 3 4 5
19. Physically Abusing Others	1 2 3 4 5	39. Believing You Are Inferior To Others	1 2 3 4 5
20. Using Alcohol to Cope with Problems	1 2 3 4 5	40. Believing You Are Better Than Others	1 2 3 4 5
21. Using Drugs to Cope with Problems	1 2 3 4 5	41. Seeing Things Without Apparent Cause	1 2 3 4 5
		42. Hearing Things Without Apparent Cause	1 2 3 4 5
		43. Experiencing Confusion	1 2 3 4 5
		44. Memory	1 2 3 4 5

MEDICAL HISTORY (Do you have now, or have you ever had any of the following ?)

__High Blood Pressure	__Head Injury	__Blood Disorders	__Problems with Muscles,
__Cancer	__Asthma	__HIV Disease	Joints, Bones.
__Diabetes	__Headaches	__Sexually Transmitted Disease	__Problems with Skin
__Stroke	__Eye Problems	__Ear Infections	__Shortness of Breath
__Heart Problems	__Arthritis	__Ulcers	__Abdominal Pain
__Kidney Problems	__Seizures	__Vomiting	__Loss of Sexual Interest
__Problems with teeth/gums	__Tuberculosis	__Gastro-Intestinal Problems	__Loss or Increase in Appetite
__Kidney Problems	__Liver Disease	__Changes in Menstrual Patter	Other:_____

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PRIOR MEDICAL HOSPITALIZATIONS (Include dates, reason and name of hospital).

PRIOR SURGERIES (Include type of surgery, date and hospital/clinic).

ALLERGIES (Are you allergic to any food or medication, if so describe what type of reaction).

PERSONAL PHYSICIAN _____ ADDRESS_____

TELEPHONE: (_____)_____. DATE OF LAST EXAM _____.

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	**Dosage**	**For What Purpose are you taking this Medication**

CHEMICAL HISTORY

Have you ever felt like you should cut down on your alcohol or other drug use? (Including prescription drugs)?	{ }Yes	{ }No
Has a friend or relative discussed concerns about your use?	{ }Yes	{ }No
Have you ever felt guilty about drinking or drug use ?	{ }Yes	{ }No
Have you ever had to take a drink or use a drug to steady your nerves ?	{ }Yes	{ }No
Are you a recovering alcoholic or recovering drug addict ?	{ }Yes	{ }No
Have you experienced negative consequences as a result of your use.	( )Yes	{ }No
Do you are others have concerns about your gambling.	( )Yes	{ }No

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PSYCHIATRIC TREATMENT (hospitalizations/outpatient TX., date, reason and facility)

CURRENT PSYCHIATRIC CARE (Name, address, phone number of psychiatrist.)

IS THERE ANY FAMILY HISTORY OF:		**INDICATE THE AMOUNTS OF THE FOLLOWING SUBSTANCES YOU USE ON A DAILY BASIS.**	
__Alcoholism __Cardiac Problems __Sexual Abuse __Physical Abuse __Domestic Violence	__Drug Dependency __Mental/Emotional Problems __Diabetes __Epilepsy or Seizure Disorder __ Other _____	__Alcohol _____ __Coffee _____ __Tea _____	__Tobacco_____ __Drugs_____ __Other _____

Briefly describe what your goals are for counseling: _____

_____

_____

_____

_____ _____
Date Signature of Patient/Guardian

_____ _____
Date Signature Witness