PEER COUNSELING
PARTICIPANT ASSESSMENT

Date:___________ Peer Counselor: _________________________________

Participant Name:____

E-Mail: ____

Address:____Phone:_______________

Emergency Contact:______________________________Phone:_______________

1) APPEARANCE OF INDIVIDUAL:
Well groomed, frail, detached, sad, cheerful – other observations.

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2) EMOTIONAL ISSUES:
Appears depressed, angry, crying, anxious or nervous, grieving, lonely, does not show emotions, has suicidal thoughts.

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3) SOCIAL SUPPORTS:
Support system, social activities, religious affiliation, friends, family, previous counseling experience.

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4) HOW DO THEY SPEND THEIR TIME?
Family, friends, community interest-involvement, TV, music, reading, art, community center, clubs, out of the house activities, etc.

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5) LIVING CONDITIONS:

Own Home______________________Apartment_________________
Board and Care__________________With Family________________
Other___________________________Pets_______________________
Well cared for Yes,_________________No,__________________

Environment is cluttered Yes,________No,_______
Clean Yes,________No,________Smokes_________

List others in household and any problems between people in the house. (Suspected abuse, alcohol, drugs)

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6) Check any health problems the participant has and note any comments briefly:

CARDIAC/HEART	**RESPIRATORY/LUNGS**	**DENTAL PROBLEMS**
High Blood Pressure______	Emphysema/COPD_____	Yes________ No________
Heart Disease____________	Tuberculosis___________	
Heart Attacks____________	Asthma_______________	**GASTROINTESTINAL/**
Strokes_________________	Bronchitis/Pneumonia___	**STOMACH & DIGESTION**
Angina_________________	Shortness of Breath_____	Recent weight gain/loss_____
		how much, how long?______
NEUROLOGICAL/BRAIN	**ORTHOPEDICS/MOBILITY**	Colitis___________________
Epilepsy/Seizures_________	Arthritis_________________	Ulcer____________________
Fainting Spells___________	History of Falls_________	Nausea/Vomiting__________
Memory Loss____________	Uses Walker___________	
Dementia_______________	Uses Cane____________	**GENERAL**
Other_________________	Uses Wheel Chair_____	Cancer__________________
		Diabetes________________
ALLERGIES	**SENSORY**	Sleep Problems___________
________________________	Hearing Difficulty_______	Other____________________
________________________	Vision Difficulty________	________________________

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Check if participant receives: ☐ **Medicare** ☐ **MediCal** ☐ **SSI or**
☐ **CAPI (Cash Assistance Program for Immigrants)**

Are you a Veteran? ☐ **Yes** ☐ **No**

7) DIET:
Eating habits, special diet, Meals on Wheels, who prepares meals, what sort of beverages do you prefer. Use of alcohol past, present.

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8) FINANCIAL ISSUES:
Worry or complaints about money, medical/dental health insurance, housing, food, utilities, credit problems, receives help from others.

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9) PARTICIPANTS AREAS OF CONCERN: (Explain)

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10) PARTICIPANTS GOAL(S) FOR SENIOR PEER COUNSELING: (Explain)

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11) WHAT OTHER SERVICES IS PARTICIPANT USING IN COMMUNITY?:

AAS Social Worker______________________________

Community Services______________________________

Senior Center______________________________

Mental Health Counselor______________________________

Community resources, such as______________________________

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Completed by:______________________ **Date:**__________

 revised 06/21/19