SELF ASSESSMENT

Client Name: _____ Date: _____

Describe any medical problems: _____

_____

_____

When was your last physical? _____ Family Doctor: _____

	NOT AT ALL				VERY MUCH
Overall, how serious is this problem for you?	1	2	3	4	5
How has this problem affected your:					
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
Child Rearing	1	2	3	4	5
Ability to Control your Temper	1	2	3	4	5
Spirituality	1	2	3	4	5

Why did you decide to seek help now? Briefly describe your reason for contacting us: _____

_____

_____

_____

How long has this been a problem for you? _____

_____

_____

What would you like to accomplish in counseling or therapy? _____

_____

_____

CHIEF COMPLAINT (Check all that apply to you):

____ Depression
____ Poor Concentration
____ Low Energy
____ Hopelessness
____ Low Self Esteem
____ Worthlessness
____ Guilt
____ Sleep Disturbances
____ Appetite Disturbances
____ Thoughts of hurting yourself
____ Thoughts of hurting someone
____ Isolation/Social Withdrawal
____ Sadness/Loss
____ Stress
____ Anxiety/Panic
____ Heart Pounding/Racing
____ Chest Pains
____ Sweating
____ Tingling/Numbness
____ Fear of Going Crazy
____ Phobias
____ Racing Thoughts
____ Easily Agitated
____ Delusions/Hallucinations
____ Hear Voices
____ Feeling that you are not real
____ Unpleasant Thoughts
____ Feeling that things around you are not real
____ Lose Track of Time
____ Anger/Frustration
____ Argumentative
____ Easily Agitated/Annoyed
____ Defies Rules
____ Blaming Others
____ Excessive use of Alcohol or Drugs
____ Excessive use of prescription meds
____ Trembling/Shaking/Hand Tremors
____ Blackouts
____ Physical Abuse Issues
____ Sexual Abuse Issues
____ Spousal Abuse Issues
____ Obsessions/Complulsive Behaviors
____ Hot Flashes or Chills
____ Fear of Dying
____ Nausea
____ Excessive Behaviors (gambling, sex, etc.)
____ Can't Hold Onto an Idea
____ Unclear Thinking/Foggy Headed
____ Other Problems/Signs/Symptoms

Previous outpatient therapy? ____ NO ____ YES Where? _____

Outcome of treatments: _____

Previous psychiatric hospitalizations: _____

Current medications and dosages: _____

_____

_____