Spokane Holistic Healing

Spokane Holistic Healing Client Handout

Client Assessment Form

Confidential – For Professional Use Only

I. CLIENT INFORMATION

- **Full Name:** _____
- **Date of Birth:** ___ / ___ / _____
- **Age:** _____
- **Gender Identity:** _____
- **Preferred Pronouns:** _____
- **Address:** _____
- **Phone Number:** _____ (Home/Cell)
- **Email:** _____
- **Emergency Contact:** Name: _____ Relationship: _____ Phone: _____
- **Primary Care Physician:** _____ Phone: _____

II. REASON FOR SEEKING COUNSELING

1. What brings you to therapy? (Briefly describe your concerns)

   _____

2. How long have you been experiencing these concerns?
   - ☐ Less than a month
   - ☐ 1–6 months
   - ☐ 6+ months
   - ☐ 1+ year
3. Have you received counseling before?
   - ☐ Yes (When? _____ For what? _____)
   - ☐ No

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III. MENTAL HEALTH HISTORY

1. Have you ever been diagnosed with a mental health condition?
    - ☐ No
    - ☐ Yes (Specify: _____)
2. Have you ever been hospitalized for psychiatric reasons?
    - ☐ No
    - ☐ Yes (When? _____ Reason? _____)
3. Are you currently experiencing any of the following? *(Check all that apply)*
    - ☐ Depressed mood
    - ☐ Anxiety, excessive worry
    - ☐ Panic attacks
    - ☐ Suicidal thoughts
    - ☐ Self-harm
    - ☐ Difficulty sleeping
    - ☐ Low energy/fatigue
    - ☐ Difficulty concentrating
    - ☐ Mood swings
    - ☐ Hallucinations or delusions
    - ☐ Substance use concerns
    - ☐ Other (describe): _____

IV. SUBSTANCE USE

1. Do you use alcohol or drugs?
    - ☐ No
    - ☐ Yes (Type: _____ Frequency: _____)
2. Have you ever been in treatment for substance use?
    - ☐ No
    - ☐ Yes (When? _____ Where? _____)

V. MEDICAL HISTORY

1. Do you have any current medical conditions?
    - ☐ No
    - ☐ Yes (List: _____)

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2. Are you currently taking any medications?
    - ☐ No
    - ☐ Yes (List: _____)
3. Any history of head injuries, seizures, or other neurological concerns?
    - ☐ No
    - ☐ Yes (Explain: _____)

VI. SOCIAL & RELATIONAL HISTORY

1. Relationship status:
    - ☐ Single
    - ☐ In a relationship
    - ☐ Married
    - ☐ Separated/divorced
    - ☐ Other: _____
2. Do you have a strong support system?
    - ☐ Yes
    - ☐ No
3. Describe your relationship with family and friends:

VII. EMPLOYMENT & EDUCATION

1. Employment status:
    - ☐ Employed (Job title: _____)
    - ☐ Unemployed
    - ☐ Student
    - ☐ Retired
    - ☐ Other: _____
2. Any work or school-related stress?
    - ☐ No
    - ☐ Yes (Explain: _____)

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VIII. COPING & STRENGTHS

1. How do you typically cope with stress?

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2. What activities bring you joy or relaxation?

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3. What personal strengths do you have that help you in difficult times?

IX. RISK ASSESSMENT

1. Have you ever had thoughts of self-harm or suicide?
   - ☐ No
   - ☐ Yes (When? _____)
2. Do you currently have suicidal thoughts?
   - ☐ No
   - ☐ Yes (Explain: _____)
3. Do you have a history of aggression or harm towards others?
   - ☐ No
   - ☐ Yes (Explain: _____)

X. TREATMENT GOALS

1. What are your goals for therapy?

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2. What do you hope to gain from counseling?

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CLIENT CONSENT

I acknowledge that the information provided is accurate to the best of my knowledge. I understand that therapy is a collaborative process and that my participation is key to progress.

Client Signature: _____ Date: ___ / ___ / _____