Client Self-Assessment Form

The information in this self-assessment is for the use of your therapist in the evaluation process. All material contained in this questionnaire will remain confidential.

When you complete this form, please:

1. Answer all questions that apply as fully as possible; print or write clearly; skip questions that don't apply
2. Be as specific as possible in regard to names, dates, ages, etc.
3. Write on the back side of the paper, if you need more space
4. **Be sure to complete this first page of demographic information and the symptom checklist on the back**.

NAME _____ DATE _____

NAME OF PARENT/GUARDIAN (if under 18 years):

_____

ADDRESS_____

EMAIL_____

TELEPHONE Home _____ May I leave a message? _____
Cell _____ May I leave a message? _____

AGE _____ DATE OF BIRTH _____ SS# _____

PLACE OF BIRTH _____ REFERRED BY _____

Emergency Contact _____ Relationship to you _____

Address_____

Phone Number (Home) _____ (Cell)_____

Primary Care Physician _____ Phone _____

Please **check** any symptoms you have and **circle** the most important symptoms:

- ☐ depressed
- ☐ headaches
- ☐ feel inferior
- ☐ trouble breathing
- ☐ dizziness
- ☐ early morning awakening
- ☐ bowel disturbances
- ☐ fast heartbeat
- ☐ can't sleep
- ☐ fainting
- ☐ menstrual problems
- ☐ problems with sexual function or drive
- ☐ sexual compulsion or addiction
- ☐ can't concentrate
- ☐ numbness or tingling
- ☐ can't make decisions
- ☐ racing thoughts
- ☐ feel hopeless
- ☐ unusual feelings
- ☐ feel tired
- ☐ hearing voices/ hallucinating
- ☐ lonely
- ☐ angry
- ☐ overambitious
- ☐ sleeping too much
- ☐ can't keep job
- ☐ legal problems
- ☐ family conflict
- ☐ financial problems
- ☐ nervous eating/ overeating/ weight gain
- ☐ lack of appetite/ not eating/ weight loss
- ☐ nausea/vomiting
- ☐ excessive gambling
- ☐ excessive drinking
- ☐ drugs
- ☐ can't relax
- ☐ feel panicky
- ☐ temper outbursts
- ☐ hands shake
- ☐ hearing difficulty
- ☐ feel tense
- ☐ difficulty communicating
- ☐ social isolation
- ☐ relationship problems
- ☐ trouble with authority
- ☐ shyness/social anxiety
- ☐ domestic violence
- ☐ history of being abused
- ☐ bullied
- ☐ cutting or self-mutilation
- ☐ confusion or memory loss
- ☐ major life change or stressor
- ☐ other

Please elaborate here: _____
_____
_____

☐ Feel suicidal (if yes, do you have a plan? ☐ yes ☐ no)
Plan: _____
_____
_____

☐ Feel like injuring someone else (if yes, do you have a plan? ☐ yes ☐no)
Plan: _____
_____
_____

MARITAL STATUS ☐ Never married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

What are your current living arrangements? Please check one:

- ☐ Single Family Home
- ☐ Multi-Family Home
- ☐ Apartment
- ☐ Dorm
- ☐ Other _____

Please list those people with whom you are currently living. Include: age, work/school and your relationship:

_____
_____
_____
_____

Please list your main reason(s) for seeking help at this time:

_____
_____
_____
_____

How long has this problem(s) existed? _____
_____
_____
_____

Has anything happened recently that made things worse? _____
_____
_____
_____

In the **past 2 weeks** my problems have: ☐ Improved ☐ Stayed the same ☐ Worsened

What would you like to get out of coming for evaluation and treatment?

_____
_____
_____

Please list any serious or hereditary diseases in your family: _____
_____
_____
_____

Do you have any physical impairments, scars, disabilities, or disfigurement? If yes, please explain: _____
_____
_____
_____

MEDICAL (WOMEN)

Age of onset of periods: _____

Do you ever experience any menstrual pain or irregularity? ☐ Yes ☐ No

Do periods affect your mood? ☐ Yes ☐ No

Please explain:_____
_____

How many pregnancies have you had? _____

Have there been any complications during or following your pregnancies? ☐ Yes ☐ No

If yes, please explain (include mood swings): _____
_____
_____

Have you ever had any infertility, abortions, miscarriages, or stillbirths? If yes, please indicate which and give the date(s) and any other necessary information relevant to your care:

_____
_____
_____

Have you undergone or are you about to undergo menopause? ☐ Yes ☐ No

If yes, how has it affected you? _____
_____
_____

MEDICAL HISTORY GENERAL

Rate your physical health (check one): ☐ Excellent ☐ Good ☐ Average ☐ Declining ☐ Poor

Date of last physical check-up: _____

If problems were diagnosed, please describe: _____
_____
_____

Does your psychiatrist know you are seeking therapy? ☐ Yes ☐ No ☐ Do not see one

Name of Psychiatrist: _____

If you are seeing a psychiatrist, please describe your reason for seeing psychiatrist and diagnosis:
_____
_____
_____

Psychiatrist's Address: _____

Psychiatrist's Phone: _____

Please list any other doctors or providers you are seeing, any medical conditions you are getting treatment for, and all medications you are taking for medical conditions. Please include supplements, herbal remedies, over the counter medication, prescriptions and any homeopathic or alternative treatments:

Doctor's Name: _____

Medical Condition:_____

Medication or Treatment:_____
_____
_____

Your Height: _____ Weight: _____

Any Body Image Concerns? _____
_____
_____

List all medications /drugs you use regularly or frequently, including herbs, vitamins, and over-the-counter medications:

Drug/Medication:_____ Dose:_____ Is it helpful? ☐ Yes ☐ No

Taken for:_____

Frequency/Times:_____ Taken as prescribed?_____

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain: _____

List all serious operations, injuries, hospitalizations, serious diseases or illnesses you have had as a child, teenager, or adult: _____
_____
_____

Any long bed confinement(s)? ☐ Yes Age(s) _____ ☐ No

Have you had any of these medical problems?

- ☐ Seizures or Epilepsy
- ☐ Thyroid Problems
- ☐ Heart problems
- ☐ Fibromyalgia
- ☐ Hepatitis
- ☐ Asthma
- ☐ Anemia
- ☐ Chronic Pain
- ☐ Reproductive Problems
- ☐ Allergies to Medicines
- ☐ Glaucoma
- ☐ Urinary Problems
- ☐ Digestive Problems
- ☐ Diabetes
- ☐ Hypertension
- ☐ Hypotension
- ☐ Skin Conditions
- ☐ Arthritis
- ☐ Cancer

☐ Other (please specify): _____

Please describe your level of physical activity and daily amount of exercise: _____
_____
_____

CHILDHOOD AND FAMILY HISTORY

Describe your home life when you were growing up. _____
_____
_____
_____
_____

Have you ever lost a family member or someone close to you through death? ☐ Yes ☐ No

If so: whom did you lose, what was the date of the person's death, what was the cause of death, how did you react? _____
_____
_____

Were you raised by your: ☐ birth parents ☐ foster parents ☐ adoptive parents ☐ step parents

Are your parents: ☐ married ☐ separated ☐ divorced ☐ never married

Is there anything your counselor should know about your parents? _____
_____
_____

Father's name: _____ Still living? ☐ Yes ☐ No

Mother's name:_____ Still living? ☐ Yes ☐ No

Age at Marriage: Father _____ Mother _____

Age at Death: Father _____ Mother _____

Nationality: Father _____ Mother _____

Religious Preference: Father _____ Mother _____

Education (highest level): Father _____ Mother _____

Employment (describe job title) Father _____ Mother _____

Describe your parent's marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

As a child did you feel closest to your (check one): ☐ Father ☐ Mother ☐ Another

If another, please describe: _____

Rate your childhood life: ☐ Very happy ☐ Happy ☐ Average ☐ Unhappy

The person who had the greatest influence on my life is (describe influence as well):
_____
_____
_____

How were feelings expressed in your family? _____
_____
_____
_____

How do you think your childhood experiences affect your situation today? _____
_____
_____
_____

My mother favored: ☐ No one ☐ Me ☐ Brother ☐ Sister

My father favored: ☐ No one ☐ Me ☐ Brother ☐ Sister

My parents were: ☐ Very Strict ☐ Strict ☐ Not Strict ☐ Didn't Care

How were you disciplined while growing up? _____
_____
_____

Do you feel you were abused by your parent(s): ☐ Yes ☐ No

Did you suffer from: ☐ physical abuse ☐ verbal abuse ☐ both

My father was: ☐ reserved ☐ very demonstrative of positive feelings ☐ withholding
☐ critical and judging ☐ didn't care

My mother was: ☐ reserved ☐ very demonstrative of positive feelings ☐ withholding
☐ critical and judging ☐ didn't care

Please describe any fearful or distressing childhood experiences you have had, or anything noteworthy that was wonderful:_____
_____
_____
_____
_____

What is your earliest memory?

_____

_____

Please list your brothers and sisters in birth order and include First Name, Gender, Age, and whether they are living:

_____

_____

_____

_____

_____

_____

EDUCATIONAL HISTORY

Last grade, degree, and age completed: _____

Did you ever have special abilities or difficulties? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

Did you attend special needs program(s)? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

Did you have any problems going to school? ☐ Yes ☐ No If yes, explain:

_____

_____

_____

Did you have any difficulty with teachers during your educational years? ☐ Yes ☐ No

Describe any pattern of difficulty with teachers: _____

_____

_____

_____

How would you rate yourself on the following during growing up years? (Please check appropriate box for each category)

ATHLETICS ☐ Active ☐ Average ☐ Less than Average ☐ None
GRADES ☐ Honor Roll ☐ Average ☐ Below Average ☐ Varied
POPULARITY ☐ Popular ☐ Average ☐ Unpopular ☐ Loner
DATING ☐ Popular ☐ Average ☐ Unpopular ☐ Loner

During your childhood did you tend to be a ☐ leader ☐ follower ☐ loner
During your adolescence did you tend to be a ☐ leader ☐ follower ☐ loner

OCCUPATIONAL HISTORY

Are you currently employed? ☐ Yes ☐ No

Your current position: _____

What kind of work do you do? _____
_____

How long have you held this position? _____

If married, is your spouse employed? ☐ Yes ☐ No

His/her current position:_____

What kind of work does he/she do?_____

How long has he/she held this position?_____

If you have had a pattern of changing jobs, please describe your job history and pattern:
_____
_____
_____
_____

If unemployed, how long and why? _____
_____
_____
_____

MARITAL HISTORY

Marital Status: ☐ single ☐ living together ☐ married ☐ separated ☐ divorced ☐ widowed

Date of marriage: _____

How long did you know your spouse before marriage? _____

Were you (or your spouse) pregnant when you got married? _____

Any previous marriages? ☐ Yes ☐ No If yes, please describe:_____
_____
_____

Previous spouse name:_____

Date of marriage:_____ Date of divorce _____

Any children? ☐ Yes ☐ No Who has custody?_____

Has your spouse been previously married? ☐ Yes ☐ No

Date of marriage:_____ Date of divorce _____

Any children? ☐ Yes ☐ No Who has custody?_____

Are you seeking therapy/counseling because of problems in your marriage? ☐ Yes ☐ No

If yes, please explain:_____
_____
_____

SEXUAL HISTORY

When and how did you first learn about sex? _____
_____
_____

At what age was your first sexual experience? _____ Was this: ☐ positive ☐ negative

What were your parent's attitudes toward sex? _____
_____
_____

Is your sex life satisfactory? ☐ Yes ☐ No Are you able to experience arousal? ☐ Yes ☐ No

Are you able to experience climax? ☐ Yes ☐ No

Do you have any problems in obtaining sexual satisfaction, or sharing it with a partner? ☐ Yes ☐ No If yes, please describe:_____
_____
_____

Are gender or sexual orientation concerns part of your reason for seeking treatment? ☐ Yes ☐ No If yes, please describe: _____
_____
_____

Do you use birth control? ☐ Yes ☐ No If yes, what kind? _____

Have your ever been sexually assaulted, harassed, raped or sexually abused? ☐ Yes ☐ No
If yes, please explain:_____
_____
_____
_____
_____

Have you ever been physically abused? ☐ Yes ☐ No If yes, please explain:_____
_____
_____
_____
_____

MENTAL HEALTH HISTORY

Have you ever had psychotherapy and/or counseling? ☐ Yes ☐ No

If yes, when:_____ Where: _____
How long? _____
With whom? _____ Phone number: _____
Reason: _____
_____

Was it helpful? ☐ Yes ☐ No What was helpful (describe): _____
_____
_____

Anything you didn't like about the experience? _____
_____
_____

Briefly describe your basic personality: _____
_____
_____

What do other people think of you? _____
_____
_____

What are your strengths? _____
_____
_____

What are your vulnerabilities?_____
_____
_____

Have you ever taken medication for emotional problems in the past? ☐ Yes ☐ No
If yes, please list and indicate whether or not you found them helpful: _____
_____
_____

Have you ever been hospitalized for emotional reasons or substance abuse? ☐ Yes ☐ No

If yes, please indicate the following: Date_____ How long?_____

Where (name town & facility):_____

Reason:_____
_____
_____

Have you ever thought of harming yourself? ☐ Yes ☐ No

Do you cut or self-mutilate? ☐ Yes ☐ No If yes, please explain:_____
_____
_____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, please give the date(s) and attempt method(s): _____
_____
_____

Have any family members attempted suicide? ☐ Yes ☐ No If yes, give date(s), how, and name relationship: _____
_____
_____

Have any family members been hospitalized for emotional reasons, had addiction problems, committed suicide, been diagnosed with mental illness or had severe mood swings?
☐ Yes ☐ No

If yes, please list their relationship to you and what the problem was:
Relationship_____ Problem_____
Relationship_____ Problem_____

Please rate yourself on a **scale of 1 to 10**: ('10' signifying you excel in, '5' signifying you are average in, and '1' signifying you have great difficulty with):

_____ I can deal constructively with reality
_____ I can adapt to change
_____ I am free from symptoms that are produced by tensions and anxieties
_____ I find more satisfaction in giving than receiving
_____ I can relate to other people in a consistent manner with mutual satisfaction
_____ I direct my angry energies into creative and constructive outlets
_____ I have a capacity to love

Areas of your life where you exhibit generosity or are successful:_____
_____
_____

Do you have coping skills that you use when you are stressed or upset? ☐ Yes ☐ No

If yes, please describe your strategies and how helpful they are: _____
_____
_____
_____

SUBSTANCE USE

How much alcohol do you drink in an average week? _____

Type of Drink_____ Frequency of Use_____

Date of Last Use_____ Age of First Use_____

Can you stop drinking without difficulty after 1 or 2 drinks? ☐ Yes ☐ No
Do you often drink more than you intend? ☐ Yes ☐ No
Do you routinely drink in certain situations or certain times? ☐ Yes ☐ No
In what situations are you most likely to drink?_____
_____

Do you use any of the following (indicate if you have used previously):

Substance	**Amount Used**	**Frequency of Use**	**Date Last Used**	**Age Started Using**
Cocaine				
Marijuana				
Barbiturates/Tranquilizers				
Amphetamines				
Hallucinogens				
Over the Counter/Rx Pills				
Crystal Methamphetamine				
Inhalants				

What are your drug/alcohol preferences?_____
_____
_____

Do your spouse, parent(s) other relatives or friends ever worry or complain about your drinking or drug use? ☐ Yes ☐ No

Have you had any financial problems as a result of your substance use such as excessive debt, loss of income due to job loss, or spending cost of living money (i.e., rent money) on drug use? ☐ Yes ☐ No If yes, please describe:_____
_____
_____

Have you had any problems on the job as a result of your substance use such as lateness, absenteeism, arguments or problems with coworkers and bosses, poor productivity, difficulty concentrating, loss of employment, suspension or warnings on the job? ☐ Yes ☐ No
If yes, please describe:_____
_____
_____
_____

When under the influence of a substance, are you more aggressive, engage in dangerous behavior such as driving under the influence, operating equipment or caring for children? ☐ Yes ☐ No
If yes, please describe:_____
_____
_____
_____

Have you had any family problems as a result of your substance use such as conflict with family members, negligence in caring for dependents or irresponsible behavior toward other family members? ☐ Yes ☐ No If yes, please describe:_____
_____
_____
_____

Have you lost interest in socializing with others who do not use substances or in activities which do not include substance use? ☐ Yes ☐ No If yes, please describe:_____
_____
_____
_____

How many of your friends use alcohol more than once per week?
☐ less than 20% ☐ less than 50% ☐ 50% or more

How many of your friends use other substances such as marijuana, cocaine, heroin, etc.?
☐ less than 20% ☐ more than 20%

Have you had any medical problems as a result of your substance use, such as, frequent hangovers, memory loss, seizures, hallucinations, breathing problems, overdose or symptoms of withdrawal when not using? ☐ Yes ☐ No If yes, please describe:_____
_____
_____
_____

Have you had any prior treatment for substance abuse? ☐ Yes ☐ No If yes, please describe:
_____
_____
_____

Have you ever attended AA, NA, CA or other 12-step programs? ☐ Yes ☐ No If yes, please describe the circumstances, how often you attend(ed) and your thoughts about the process:
_____
_____
_____

Do you have a sponsor? ☐ Yes ☐ No Are you using your sponsor? ☐ Yes ☐ No

Is there a history of substance use in your family? ☐ Yes ☐ No If so, please indicate which members have been or are affected?_____
_____
_____

What happens to you when you use your substance of choice and how does it affect you attitude, mood, and behavior change?

Drug of Choice	Attitude Change	Mood Change	Behavior Change

Have you tried to control your use by doing any of the following:

- Cutting back on how much or how quickly you use? ☐ Yes ☐ No
- Changing the time of day or situation in which you use? ☐ Yes ☐ No
- Trying to substitute other substances to try and cut back on use? ☐ Yes ☐ No
- Using other substances or drugs to control or take away uncomfortable feelings after using your primary substance? ☐ Yes ☐ No
- Attempting to abstain temporarily? ☐ Yes ☐ No

If you check any of the above, how have attempts to control your use worked? _____
_____
_____

Have you ever tried to stop using, if yes, what happened?_____
_____
_____

Have you had any legal problems as a result of your substance use such as: DWI, disorderly conduct, assault, theft, possession, or dealing of substances? ☐ Yes ☐ No If yes, please describe: _____
_____
_____

WORLD VIEW/PHILOSOPHY/RELIGIOUS/SPIRITUAL HISTORY

Please briefly describe your spiritual beliefs, life philosophy, political or world view:
_____
_____

Religious/spiritual background of spouse/partner:_____
_____

Have either yourself or your spouse changed your religious or spiritual practice? ☐ Yes ☐ No
If yes, please explain:_____
_____

How frequently do you attend religious services? _____

Where did you attend in childhood? _____

Parents' religious practice: Father_____ Mother_____

Is philosophy, politics, religious or philosophical belief a source of conflict in your relationship(s)? ☐ Yes ☐ No If yes, please explain: _____

Are your beliefs a source of comfort and/or distress? ☐ Yes ☐ No If yes, please explain:
_____
_____

Do you hold membership in any church, synagogue, or other religious group? ☐ Yes ☐ No

Name of your religious, spiritual or philosophical group:_____

Does your world view, philosophy, political or spiritual belief affect your life choices?
☐ Yes ☐ No If yes, please describe: _____
_____
_____

Anything else you would like me to know?_____
_____
_____
_____
_____

Client Signature_____ Date _____