Amber Sky Counseling

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Comprehensive Assessment

Please fill out the following confidential information. This will be reviewed in our first session. You are not obligated to answer anything you are not comfortable answering. Thank you.

Client's name: ____ Client's date of birth: ________________________

Please fill out this form and bring it to your first session.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication? ☐ Yes ☐ No

Please list: ____

____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? __________ What types of exercise to you participate in?

____

4. Please list any difficulties you experience with your appetite or eating patterns:

____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐ Yes ☐ No

If yes, for approximately how long? ________________________

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? ______________________________

7. Are you currently experiencing any chronic pain? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

8. Do you drink alcohol more than once a week? ☐ Yes ☐ No

9. How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ Yes ☐ No

If yes, for how long? ___________________

On a scale of 1-10, how would you rate your relationship? ___________

11. What significant life changes or stressful events have you experienced recently:

____

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes	No	______________
Anxiety	Yes	No	______________
Depression	Yes	No	______________
Domestic Violence	Yes	No	______________
Eating Disorders	Yes	No	______________
Obesity	Yes	No	______________
Obsessive Compulsive Behavior	Yes	No	______________
Schizophrenia	Yes	No	______________
Suicide Attempts	Yes	No	______________

ADDITIONAL INFORMATION:

1. Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Are you currently experiencing a divorce or any other legal issues? ☐ Yes ☐ No

3. Do you have a history of domestic violence or trauma of any kind? ☐ Yes ☐ No

4. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, describe your faith or belief:

____

5. What do you consider to be some of your strengths?

____

____

____

____

6. What do you consider to be some of your weaknesses?

____

____

____

____

7. What would you like to accomplish out of your time in therapy?

____

____

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