Self-Assessment Form

Today's Date_____

Name_____

Additional Names of clients participating in therapy?

_____

Address _____

Phone (Primary) _____ (Cell phone) _____

Age _____ Date of Birth _____/_____/_____

SS#_____

Marital Status: (circle one) Single Married Partnered Divorce

Are you here for individual counseling or couples counseling: _____

Phone (Primary) _____ (Cell phone) _____

Are phone messages okay? Y/N

Do you want to receive emails? Y/N If so, what is your email address:

_____

Are you in school? Y/N If so how are you functioning?

_____

Are you employed Y/N If so, where and how are you functioning at work?

_____

_____

If unemployed, what is your employment history for the last few years?

_____

_____

Do you attend church? Y/N If so, where_____

Emergency contact _____

Phone Number _____ Relationship _____

Have you participated in any therapy before? Y/N If yes, when? _____

Where? _____

Have you ever seen a psychiatrist or psychologist? Y/N If yes, when? Where?

_____

Presenting Problem
Briefly describe the problem or concern you are currently experiencing.

_____

_____

_____

_____

How have you been coping? _____

_____

_____

Has this problem prevented you from functioning in daily activities? If so, please explain_____

_____

_____

What are your current symptoms and how long have they been present?

_____

_____

_____

Have there been any recent life changes? If so, when did the changes occur and please explain the situation?

_____

_____

Please circle any concerns with the following:

marriage / divorce-separation / pre-marital / adoption/spirituality-faith / culture-ethnicity / weight / work-career / relationships /grief-loss / custody / other addictions / self-esteem / sexual identity / sexual dysfunction/fears-phobias / intimacy / children / finances / anger / aging / cutting / parents / in-laws / communications / hopelessness / past trauma

/stress / mood disorders / infertility / worry /life transitions / parenting /adjustment / health / guilt / shame

Please list any concerns that are not listed _____

_____

Are there religious or spiritual beliefs that are important to you that you would like to discuss? If so, please discuss?

_____

Military History
Y/N If yes, list branch and years of service
_____Status _____

Medical History

Doctor's name and phone number:

_____

When was your last exam or office visit?

_____

Do you sleep through the night? Y/N, if no, please explain

_____

If the presenting problem is related to a medical problem, please explain and include the date things changed?

_____

Have you experienced any weight gain or weight loss recently? If so, how long has this been going on? Please explain in detail

_____

_____

_____

If you are taking medications for mental illness, please list the doctor(s) treating you, as well as the medications:

_____

_____

_____

_____

Are you being referred by a doctor for counseling/therapy? _____

Substance abuse / Addiction history

Alcohol Use

- No alcohol uses
- Current use frequency/Amount:
- Past Alcohol Abuse

If you checked past alcohol abuse, do you attend AA meetings? Yes/No if so, do you have a sponsor? Yes / No
Please explain

_____

Drug Use

- No drug uses
- Current use
- Past Drug use

If you answered yes to past drug use, do you attend NA meetings? Yes/No if so, do you have a sponsor? Yes / No
Please explain

_____

How are you functioning in your current relationships with spouse/partner, family and friends?

_____

_____

_____

_____

How would you describe your friendships: close distant conflicted?

Are you a social person? If not, have you always been this way or have you noticed changes?

_____

_____

_____

Do you have any problems with sexual functioning? Y/N

Are you on any medications, or than the ones listed before? Y___N___ If so, please list on a separate piece of paper.

Family History:

Family Members Living in Household (continue at bottom of form if necessary):
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Do you have children not living with you (include ages)? _____

_____

_____

Have you or a family member ever been hospitalized for a mental or emotional illness? Y/N_____ If yes, please explain date, where, reason:

_____

_____

Do you feel supported by your family and friends, if so by whom?

_____

_____

_____

Who provided most of your care growing up?

_____

Did you have any significant changes in caregivers?

_____

Were you happy in your childhood Y/N? _____

_____

_____

Please answer the following questions:

Have you had any of these? Check All that Apply

Suicidal Ideation:

- No thoughts
- Suicidal thoughts

- Intent of suicide without plan
- Thoughts of Intent of suicide with plan
- Suicidal thoughts in past year
- Suicide attempt(s) in past year
- Family/peer history of suicidal thoughts/attempts

Homicidal Tendencies:

- No thoughts
- Homicidal thoughts
- Intent of homicide without plan
- Thoughts of Intent of homicide with plan
- Homicidal thoughts in past year
- Violence in past year
- History of assault/temper

Is there a history of Sexual Abuse Y/N or Physical Abuse Y/N?

Is there a history of self-mutilation? _____

Have you had any legal problems? If so, please explain?

_____

_____

Therapy Goals

What are your goals of therapy?

_____

_____

_____

Insurance Carrier

Name of Insurance Carrier_____

ID #_____

Address of Insurance Carrier_____

Phone Number _____

Are you covered for mental health under this plan Y/N?

Primary Member Name _____DOB_____

Primary Member SS#_____

Financial Responsibility

First *MI* *Last*

Name: _____ D/O/B _____

Address: _____

Phone: _____ cell phone: _____

Referrals:

Was this a referral? If so, who referred you?

_____

How did you hear about us? i.e. friend, psychology today, good therapy, open path, Christian directory, the website, internet? _____

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Signature_____

Signature_____

Date_____

Thank you for taking time to complete this form!

****

office use only*

Diagnostic impression code: _____ Insurance Y/N _____