Self Assessment

Client Name: _____ Date: _____/_____/_____

What is happening in your life which resulted in this appointment?

_____

_____

What would you like to see accomplished in therapy?

_____

_____

Have you been in counseling before? ____ Yes ____ No

If yes, with whom? _____

Dates attended: _____

What was the Outcome:_____

Have you ever been hospitalized in a Psychiatric Facility? ____ Yes ____ No

If yes, where, dates and reason for hospitalization: _____

_____

Chief Complaint – Check all that apply to you.

- O Depression
- O Low energy
- O Low self-esteem
- O Poor concentration
- O Hopelessness
- O Worthlessness
- O Guilt
- O Sleep disturbance (more / less)
- O Appetite disturbance (more / less)
- O Thoughts of hurting yourself
- O Thoughts of hurting someone
- O Isolation / social withdrawal
- O Sadness / loss
- O Stress
- O Anxiety / panic
- O Fear of dying
- O Fear of going crazy
- O Obsessions / compulsive behaviors
- O Racing Thoughts
- O Excessive behaviors (spending, gambling, sex, etc.)
- O Delusions / hallucination
- O Not thinking clearly / confusion
- O Feeling that you are not real
- O Feeling that things around you are not real
- O Lose track of time
- O Unpleasant thoughts won't go away
- O Anger / frustration
- O Easily agitated / annoyed
- O Defies rules
- O Blames others
- O Argues
- O Excessive use of drugs and/or alcohol
- O Excessive use of prescription medications
- O Blackouts
- O Physical abuse issues
- O Sexual abuse issues
- O Spousal abuse issues
- O Other problems / symptoms:

  _____

  _____

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  _____

Signture_____Date_____