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Date of Appointment: _____ Time of Appointment: _____

Client Name: _____ Age: _____ Date of Birth: _____

Gender: □ Male □ Female □ Transgender Preferred Name/Nickname: _____

Ethnicity: □ Hispanic □ Non-Hispanic Race: _____

How did you find out about this service? _____

Presenting Problem (Briefly describe the issues/problems which led to your decision to seek therapy):

_____

_____

_____

How severe, on a scale of 1-10, do you rate your presenting problems? _____

MOST SEVERE 1 2 3 4 5 6 7 8 9 10 LEAST SEVERE

How long has this problem been causing you distress?

□ One week □ One month □ 1 – 6 Months □ 6 Months – 1 Year □ Longer than one year

How do you rate your current level of coping on a scale of 1 – 10? _____

UNABLE TO COPE 1 2 3 4 5 6 7 8 9 10 ABLE TO COPE

What efforts have you taken to address the problem?

_____

_____

_____

What do you feel the cause to this problem is/was?

_____

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Have you had any significant life changes? If so, when and what were they?

_____

_____

What is your typical response to life stressors?

□ Share with others □ Isolate □ Yell □ Sleep □ Medicate through _____

□ Eat □ Other: _____

PSYCHIATRIC/PSYCHOLOGICAL HISTORY:

Are you currently being seen by a counselor? □ Yes □ No

If yes, name of current counselor _____Length of Treatment _____

Are you currently being seen by a psychiatrist? □ Yes □ No

If yes, name of current psychiatrist _____ Length of Treatment _____

Have you ever been diagnosed with a mental health, emotional or psychological condition? □ Yes □ No

If yes, what diagnosis were you given? _____ _____

When? _____

By Whom? _____

Previous counseling/hospitalizations for mental health/drug and alcohol concerns

Dates of Service	Place/Provider	Reason for Treatment	Were the Services Helpful

SAFETY CONCERNS:

Are you presently suicidal? □ Yes □ No If Yes, please explain:_____

Have you ever attempted to commit suicide? □ Yes □ No If yes, when and how? _____

_____

Is there a history of suicide in your immediate and/or extended family? □ Yes □ No

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Are you presently homicidal? □ Yes □ No If Yes, please explain: _____

_____

Additional Information: (please add additional information as needed to address past and current safety issues): _____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

Please identify if any members of your family have had a history of any of the following mental health/drug/abuse/legal concerns.

Family History	Depression	Anxiety	Bipolar Disorder	Schizophrenia	ADHD/ ADD	Trauma History	Abusive Behavior	Alcohol Abuse	Drug Abuse	Incarceration
Self										
Mother										
Father										
Sister										
Brother										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										
Biological Child										
Other										

Current Marital/Relationship Status: □ Single □ Living Together □ Married □ Separated □ Divorced □ Widowed

If applicable, list divorces and separations:

_____

How do you identify yourself: □ Heterosexual □ Homosexual □ Bisexual □ Questioning

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What do you think is important for us to know about your significant relationships – current & past?

_____

_____

FAMILY COMPOSITION

Spouse/Significant Other's Name: _____ Age: _____

□ Living with client □ Not living with client

Employed Currently: □ Yes □ No If Yes, place of employment: _____

Occupation: _____

Please list the names, ages, relationships and other relevant information regarding all immediate family members whether living in- or outside the home.

Family Members Name	Age	Relationship to You	Living	Deceased

Children: □ Yes □ No

Name	Age	Gender	Living	Deceased	Living with Client
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No

Would you like any family member involved in your treatment?

□ Yes □ No

If yes, who would you like involved? _____

Contact Information: _____

RECENT LOSSES:

□ Family Member □ Friend □ Health □ Lifestyle □ Job □ Income □ Housing □ None

Who? _____ When? _____ Nature of Loss? _____

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HOUSING:

Would you consider your housing to be: □ stable □ unstable

Do you currently:

□ Own □ Rent □ Live with relatives/friends (temporary) □ Emergency Shelter

□ Live with relatives/friends (permanent) □ Homeless □ Transitional Housing

How long have you lived in your current living situation? _____

How often have you moved in the past two years? _____

What else do you think is important for us to understand about your housing/living situation?

_____

_____

EMPLOYMENT:

Currently Employed? □ Yes □ No **If employed,** what is your occupation? _____

Where are you working? _____

How long? _____ Days/Months/Years

Do you enjoy your current job? □ Yes □ No

What do you like/dislike about your job? _____

_____

_____

If you are not currently employed, how long has it been since you last worked? _____ Months/Year

What was your occupation before becoming un-employed? _____

What led to becoming un-employed? _____

Are you a student? □ Yes □ No **If yes:** □ Full-Time □ Part-Time Area of Study: _____

Are you currently in the military? □ Yes □ No

Have you served in the military? □ Yes □ No

HEALTH HISTORY:

How would you describe your overall health? _____

Do you have any health issues? □ Yes □ No If Yes, please list below.

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Do you have any recurrent medical conditions such as allergies or asthma? □ Yes □ No

If yes, please list: _____

Please list below current medical problems, physical limitations, sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood infections, eating disorders, knee or back injuries, asthma, etc.

Medical Conditions	Are you currently receiving treatment?	Provider	Does this condition cause stress or impairment at this time?	What have you found that helps?

Do you currently take any medications? □ Yes □ No

Please list medications (including psychotropic, over-the-counter, herbal remedies) that you have taken in the past six (6) months.

Medication	Dosage	Frequency	Prescribed By	Reason for Medication

Are you taking the medication as prescribed? □ Yes □ No If No, please explain: _____

_____

Additional information (if needed):

_____

_____

Have you ever had a serious accident/illness or hospitalization? □ Yes □ No

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Please list all past hospitalizations, surgeries, accidents, or illnesses in the chart below:

Reason for Previous Hospitalizations, Accident, Illness	Date/Location of Hospitalization

Are you aware of any medical problems related to you or your mother's pregnancy or your birth?

□ Yes □ No □ Unknown If yes, please explain: _____

_____

Did you have any developmental delays during childhood?

□ Yes □ No □ Unknown If yes, please explain: _____

_____

Have you noticed a drop in participating in pleasurable activities?

□ Yes □ No □ Unknown If yes, please explain: _____

_____

Has there been a change in your interest in sexual activities?

□ Yes □ No □ Unknown If yes, please explain: _____

_____

Primary Care Doctor: _____ Facility: _____

Phone Number: _____

ALCOHOL/DRUG ASSESSMENT:

Current or past history of alcohol/drug use? □ Yes □ No **If Yes**, complete table below. If no history, mo ve to next section.

Do you ever drink or use more than you intend to? □ Yes □ No If yes, how often: □ Almost every time
□ Occasionally □ Seldom □ More often lately □ When under stress □ Other: _____

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Have you ever had to increase the amount of alcohol/drug you consume to get the same effect?
□ Yes □ No **If Yes**, when did you first notice this change? _____

Do you have a history of overdosing on alcohol/drugs?
□ Yes □ No If yes, when was the last OD? _____

Have you ever experienced a black out? □ Yes □ No If Yes, how often: □ Almost every time
□ Occasionally □ Seldom □ More often lately □ When under stress □ Other: _____

With whom do you typically consume alcohol? □ Friends □ Family □ N/A-Alone □ Strangers □ Other

Have you ever experienced problems related to your alcohol use? □ Yes □ No
□ Legal □ Social/Peer □ Work □ Family □ Friends □ Financial
If yes, please describe: _____
If yes, have you continued to drink/use drugs? □ Yes □ No

Substance Abuse	Age of Onset	Length of Use	Frequency of Use	Present Use
Nicotine				□ Yes □ No
Caffeine				□ Yes □ No
Alcohol				□ Yes □ No
Marijuana				□ Yes □ No
Heroine				□ Yes □ No
Inhalents				□ Yes □ No
Methamphetamines				□ Yes □ No
Barbituates				□ Yes □ No
Tranquilizers				□ Yes □ No

LEGAL INVOLVEMENT:
Please indicate by checking below your legal status.
□ No Involvement □ Probation | Length: _____ □ Parole | Length: _____
□ Charges Pending □ Prior Incarceration □ Law Suit or other Court Proceeding
Charges: _____ Probation/Parole Officer's Name: _____
Contact #: _____
Additional Information: _____

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HISTORY OF ABUSE/NEGLECT:

Type of Abuse	By whom?	At what age?	Was it reported?
□ Sexual			□ Yes □ No
□ Physical			□ Yes □ No
□ Emotional			□ Yes □ No
□ Verbal			□ Yes □ No
□ Abandoned/Neglected			□ Yes □ No

Do you feel in danger now? □ Yes □ No

What else do you feel is important for us to know? _____

_____

_____

HISTORY OF VIOLENCE:

Have you ever been accused of abusing or assaulting someone? □ Yes □ No

If yes, please complete the chart below.

Type of Abuse	By whom?	At what age?	Was it reported?
□ Sexual			□ Yes □ No
□ Physical			□ Yes □ No
□ Emotional			□ Yes □ No
□ Verbal			□ Yes □ No
□ Abandoned/Neglected			□ Yes □ No

What else do you feel is important for us to know? _____

_____

_____

STRENGTHS/RESOURCES/SUPPORTS:

What limitations do you have (if any)? _____

What strengths do you have? _____

Do you have any leisure activities/hobbies? _____

_____

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What resources do you have to help with your current problem?

_____

What experiences (past & present) will help you in improving the current situation?

_____

_____

_____

What are you (and your family) already doing to improve the current situation?

_____

Who can you count on for support? ☐ Parents ☐ Boyfriend/Girlfriend ☐ Siblings ☐ Pastor ☐ Extended Family ☐ Friends ☐ Neighbors ☐ School Staff ☐ Church ☐ Therapist ☐ Group ☐ Community Services ☐ Doctor ☐ Other: _____

SPIRITUAL HISTORY:

Do you have an active faith life? ☐ Yes ☐ No

Do you attend church regularly? ☐ Yes ☐ No

Describe the nature of your spiritual life currently: _____

_____

_____

CURRENT NEEDS/GOALS:

What do you feel is your biggest need right now? _____W

hat do you most hope to gain from coming to counseling? _____

_____

_____

If you were to pick three goals to work on, what would they be?

Goal 1: _____

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Goal 2: _____

Goal 3: _____

What else would you like for us to be aware of? _

_____

_____

_____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

INDIVIDUAL COMPLETING ASSESSMENT:

Printed Name _____ Date: _____

Signature _____ Relationship to client _____