

CLIENT SELF-ASSESSMENT

Client: _____

Date: _____

CURRENT CONCERNS

Check any of the following behaviors or concerns that you would like help with:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> alcohol use | <input type="checkbox"/> sleep | <input type="checkbox"/> temper | <input type="checkbox"/> parenting problems |
| <input type="checkbox"/> drug use | <input type="checkbox"/> memory | <input type="checkbox"/> risk taking | <input type="checkbox"/> fertility problems |
| <input type="checkbox"/> tobacco use | <input type="checkbox"/> concentration | <input type="checkbox"/> headaches | <input type="checkbox"/> financial problems |
| <input type="checkbox"/> overeating | <input type="checkbox"/> fear/phobia | <input type="checkbox"/> chronic pain | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> overworking | <input type="checkbox"/> impulsivity | <input type="checkbox"/> PMS | <input type="checkbox"/> sexual dysfunction |
| <input type="checkbox"/> obsessions | <input type="checkbox"/> depression | <input type="checkbox"/> loneliness | <input type="checkbox"/> sexual addiction |
| <input type="checkbox"/> compulsions | <input type="checkbox"/> anxiety | <input type="checkbox"/> legal problems | <input type="checkbox"/> gambling problem |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> mania | <input type="checkbox"/> social isolation | <input type="checkbox"/> work difficulties |

Other : _____

Which of the above behaviors would you most like to change? _____

HEALTH HISTORY

Current/previous psychotherapy (give name(s), dates, duration, kind of therapy and outcome):

Please describe any negative experience with a former psychotherapist or psychiatrist:

Have you ever been hospitalized for a psychiatric problem? If yes, please give details:

Current health (include any medical problems): Circle one: poor fair good excellent

Chronic health problems:

Current prescribed medications and homeopathic remedies: _____

Current complementary treatments (acupuncture, massage, etc.): _____

Name and phone no. of your primary care physician:

Name and phone no. of psychiatrist, psychotherapist, and/or other significant health care providers:

EMPLOYMENT/EDUCATION

What kind of work are you doing now? _____

How satisfied are you with the kind of work you are doing?

How satisfied are you with your current employment situation? _____ Please identify any stressors such as difficulties with supervisor, co-workers, work hours, duties, or other issues:

Current vocational goals:

Highest level of education achieved: _____

Do you have any plans to further your education? _____ If so, describe: _____

FINANCIAL/LEGAL:

Please describe any financial concerns you have:

Are you currently involved in any civil or criminal legal actions? _____ If so, please describe:

Do you have a pending workman's comp or disability claim? _____ If so, please describe:

Is it likely that evaluation or treatment reports might be required by an attorney, court, probation official, or insurance company? _____ If so, please provide specifics now: (failure to provide known information at this time might result in my disclosure of same to requestor):

LIFESTYLE:

What kind of leisure activities do you participate in? (indicate how many times per week or month you engage in these activities)

How often do you exercise? __never __rarely __occasionally __few times week __daily

What kind of exercise do you do? _____

Do you meditate or use relaxation practices? If so, please describe: _____

Describe any volunteer work you do or have done:

Describe involvement in any community, social, or religious organizations:

INTERPERSONAL RELATIONSHIPS

PERSONAL HISTORY

Siblings: Number of Brothers: _____ Brothers' Ages: _____
Number of Sisters: _____ Sisters' Ages: _____
If deceased, name/age at time of death: _____ Your age then: _____
If deceased, name/age at time of death: _____ Your age then: _____
Your sibling order: _____

Father: Occupation: _____ Health: _____ Age: _____
If deceased, age, year of death _____ Your age then: _____
Cause of Death: _____

Mother: Occupation: _____ Health: _____ Age: _____
If deceased, age, year of death: _____ our age then: _____
Cause of Death: _____

Which of the following apply to your childhood/adolescence:

- | | |
|--|--|
| <input type="checkbox"/> happy childhood | <input type="checkbox"/> school problems |
| <input type="checkbox"/> unhappy childhood | <input type="checkbox"/> family problems |
| <input type="checkbox"/> emotional/behavior problems | <input type="checkbox"/> medical problems |
| <input type="checkbox"/> legal trouble | <input type="checkbox"/> drug/alcohol use |
| <input type="checkbox"/> strong religious upbringing | <input type="checkbox"/> teased or bullied |
| <input type="checkbox"/> supportive parents | <input type="checkbox"/> friendly neighbors |
| <input type="checkbox"/> supportive siblings | <input type="checkbox"/> safe and secure neighborhood |
| <input type="checkbox"/> enjoyed school | <input type="checkbox"/> unsafe and dangerous neighborhood |

Describe your father and the relationship you had with him as a child and as an adult: _____

Describe your mother and the relationship you had with her as a child and as an adult: _____

Describe any significant positive or negative relationships you have had with relatives: _____

If you have ever been physically or emotionally abused, describe by whom, under what circumstances, and for how long:

**Did any member of your immediate or extended family suffer from alcoholism, depression, anxiety, panic attacks, or anything that might be considered a “mental disorder”? _____
If yes, please provide details:**

Has any member of your family ever been hospitalized or treated on an outpatient basis for a psychiatric problem? _____ If yes, please provide details: _____

PARTNERSHIP/MARRIAGE

What are the current issues that challenge you and your partner at this time?

Please describe your partner:

In what ways are you compatible? _____

In what ways are you incompatible? _____

How satisfied are you in this relationship now?

__not at all __very little __somewhat __moderately __highly

Please describe any significant relationship or partnership losses that have impacted you:

CHILDREN

Please list the names and ages of all of your biological children and where they reside:

Please list the names and ages of all of your stepchildren, adopted children, and foster children:

What issues challenge you as a parent at this time? _____

Which of your children have special needs? _____

Information you consider relevant regarding infertility, pregnancies, abortions or miscarriages:

SEXUALITY:

How satisfying is your sex life now?

__not at all __very little __somewhat __moderately __highly

Have you ever been sexually abused, molested, or assaulted? _____ If yes, please describe by whom, under what circumstances, and for how long:

Please describe any sexual concerns, experiences or incidents not mentioned above:

Any sexual practices or compulsions which are a problem for you or for others:

SOCIAL RELATIONSHIPS

Identify specific relationships with people with whom you feel comfortable:

Identify specific relationships with people with whom you feel uncomfortable:

With which people are you closest to now? (your inner circle): _____

How comfortable are you in social situations?

__not at all __somewhat __moderately __highly

Do you have trouble speaking up for yourself? _____ If yes, with whom or in what kinds of situations?

Describe any involvement you have in clubs, voluntary, or social organizations: _____

Describe any involvement you have/ have had with any social support groups or self-help programs:

RELIGION/SPIRITUALITY

Describe your current affiliation with a religious organization or spiritual group:

How regularly do you participate? _____

Describe your religious upbringing, parochial education, and anything particularly positive or negative about these experiences:

NODAL LIFE EVENTS

Please identify memories of life events/experiences during the following age ranges which you believe had an impact on your development, identity, and current functioning:

0-10

11-20

21-30

31-40

41-50

51-60

61-70

70+

Any other information that might be useful for me to know:
