Client Assessment

Today's Date_____

What has prompted you to seek counseling services at this time? _____
_____
_____
_____

Please circle all items which are a concern for you:

Adjustment issues
Anger issues
Anxiety
Appetite/Weight
Behavior issues
Career/job issues
Concentration
Decision making
Depression
Developmental issues
Family Concerns
Financial Concerns
Gender Identity
Grief/Loss
Health concerns
Hopelessness
Impulsivity
Legal issues
Marital concerns
Memory issues
Motivation issues
Panic/Fear
Relationship issues
Self-esteem
Sexual Orientation
Shyness
Sleep issues
Stress
Thoughts/Cognitive issues
Trauma
Other (anything not listed)

Are you having any current thoughts of hurting yourself? Please Circle: YES NO
Have you had any suicidal thoughts in the past week? YES NO
Have you had any suicidal thoughts in the past month? YES NO
Have you had any suicidal thoughts in the past year? YES NO

Are you having any current thoughts of hurting someone else? Please Circle: YES NO
Have you had any homicidal thoughts in the past week? YES NO
Have you had any homicidal thoughts in the past month? YES NO
Have you had any homicidal thoughts in the past year? YES NO

Client Assessment

Past/Current Trauma:

Have you experienced any trauma? (past or current) _____

Have you ever been:

Physically Abused/Assaulted? (please provide date) _____

Emotionally Abused/Neglected? (please provide date) _____

Sexually Abused/Assaulted? (please provide date) _____

Past Treatment:

Have you received mental health and/or substance use disorder counseling in the past? What is your perception of this treatment? Please provide dates and providers. _____

_____

_____

Have you ever been hospitalized for mental health and/or substance use treatment? Please provide dates and facility information. _____

_____

_____

Physical Health Information:

Primary Care Physician: _____

Name of practice and address: _____

When were you last seen? _____

List current physical issues: _____

_____

List any past significant physical issues: _____

_____

List all current medications: _____

_____

_____

Do you want me to contact your doctor? _____

Alcohol Use? (type and quantity) _____

Drug Use? (type and quantity) _____

Client Assessment

Education/Employment Information:

Highest level of education achieved: _____

Degree or certification information, if applicable: _____

Employer_____ Job Title_____

Relationship/Family Information:

Single ____ Married ____ Partnered ____ Separated____ Divorced ____ Other ____

Name of Partner/Spouse_____

Do you feel emotionally supported by your partner/spouse? _____

Do you have supportive people in your life? _____

Do you have children? Please list your children's names and ages: _____
_____
_____

Spirituality/Religious Information:

How would you describe your religious or spiritual belief system? _____
_____
_____

Are you supported by a faith community? _____
_____

Strengths and Goals:

What would you like to accomplish through counseling? _____
_____
_____

What are your strengths/talents? _____
_____
_____

Client Assessment

What do you enjoy doing? What makes your heart sing? _____

_____

_____

*Thank you for this information.

Client Signature_____Date_____