Initial Assessment

1. PERSONAL INFORMATION

Name*: _____ Address*: _____

City*: _____ State*: _____ Zip*: _____ Email*: _____ Cell Phone*: _____

Social Security #*: _____ Sex*: ☐Male ☐Female ☐Other: _____
DOB*: _____

Do you currently have health insurance?* Y or N? Name of Health Insurance*: _____

Name of Person Carrying Insurance*: _____ DOB for Person Carrying Insurance*: _____

Emergency Contact Name*: _____ Emergency Contact Number*: _____

Marital Status: _____ Name of Spouse or Partner (if applicable): _____

Name and Ages of Children (if applicable): _____

Place of Employment: _____ Occupation: _____

2. ONSET, DURATION, AND COURSE OF SYMPTOMS

Why are you seeking treatment?* _____

What current symptoms are you having that are bothersome to you?* _____

_____

How long ago did this start?* _____ How long does it last, and how often?* _____

Describe what it feels like*: _____

_____

3. CLIENT PSYCHIATRIC HISTORY

Have you ever been in counseling/therapy before?* Y or N? Type of Counseling/Therapy: _____

Name & City of Past Counselor/Therapist: _____ Duration of Treatment: _____

Have you ever been suicidal in the past?* Y or N? Are you currently thinking of self-harm?* Y or N?

Do you have a current plan to harm yourself?* Y or N? Do you have an intent/ability to carry out a plan?* Y or N?

Have you ever been homicidal in the past?* Y or N? Are you currently thinking of harming others?* Y or N?

Do you have a current plan to harm others?* Y or N?

Previous psychiatric diagnoses such as depression, anxiety, etc.:_____

Previous medications and dosage: _____

4. FAMILY PSYCHIATRIC HISTORY

Does anyone in your family…

Have a psychiatric diagnosis? If so, please specify: _____

Currently attend therapy? If so, what for? _____

Have a history of completing suicide? If so, what is the relationship?_____

Have a history of attempting suicide? _____

Use substances? If so, what? _____

5. MEDICAL HISTORY *Explain in detail*

Any surgeries/hospitalizations/major illnesses?:

Any head injuries?:

Any car wrecks?:

Do you frequently lose your balance or fall?:

Current medications and dosage:

Do you consume any drugs or alcohol? If so, what type, and how often?:

Is your drug/alcohol use problematic?:

6. TRAUMA HISTORY *Circle all that apply*

Prebirth Trauma Generational Trauma

Birth Trauma Death of a Parent as a Child

Emotional Abuse Physical Abuse Sexual Abuse

Neglect Lack of Food or Shelter

Bullying in School Didn't Feel Safe or Loved

Witnessed Violence Domestic Violence

Rape Death of a Spouse or Partner

Death of a Child Human Trafficking

Traumatic Medical Interventions or Procedures

Other: _____

7. PERSONAL HISTORY

Place of Birth: _____

As a child...

What was your family structure?: _____

What were your parents' occupations?: _____

How was your relationship with your family?*: _____

_____

How was your relationship with your friends?: _____

_____

How did you do in school? Did you participate in any activities?: _____

_____

Did you get in trouble at school or at home? If so, for what?: _____

As an adult...

How is your work?: _____

How are you doing financially?: _____

What is your highest degree of education?: _____

How are your relationships (both romantic and platonic)?*: _____

_____

How is your sex life?: _____

What is your family life like?: _____

What are your goals for the future?: _____

Past or current legal history*: _____

Are you currently involved in a lawsuit?*: _____

Are you currently working with an attorney? If so, whom?*: _____

Personal Goals in Therapy:

1.

2.

3.