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Client Assessment Form

We will review this form during one of our initial meetings. Please feel free to ask me any questions you may have. If certain questions do not apply to you, please write "N/A" for not applicable. If you do not remember dates or years for historical information, please estimate and indicate that the date is an estimate. I use this information to help me develop a thorough assessment and treatment plan. Thanks for taking the time to complete this form.

Identification

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone (please list the phone number(s) you would like me to use when contacting you):

_____

e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Referral:

How did you find out about my mental health practice? Did anyone refer you to me?

_____

_____

Religious, racial/ethnic identification, sexual orientation and gender

How important are spiritual concerns in your life? Do you identify with a particular religion? If so, which one?_____

Ethnicity/national origin: _____ Race: _____

What language(s) do you speak?_____

Sexual orientation:_____ Gender:_____

Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone: _____ Relationship: _____

Address:_____

Family history

Please detail important information about your family history. It is helpful for me to be aware of any family history of abuse and trauma. It is also helpful to list any family history of mental health and/or substance abuse conditions. Please include important conditions and/or concerns related to children, parents, grandparents and any other important caregivers or family members.

_____

_____

Marital/relationship history

Please detail any important information about your current and past romantic relationships. It is helpful for me to be aware of significant losses, divorces and separations. Any current or past history of couples and/or family therapy?

Please describe your reason(s) for seeking mental health treatment at the current time. If you are experiencing particular symptoms, such as depression or anxiety, please detail them here:

Please describe your therapy goals:

Mental health history

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes

If you have participated in past mental health treatment, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes

If yes, please indicate:

When? From whom? Which medications? For what? With what results?

_____

_____

_____

3. Please describe how you tend to relate with others. I am interested in how you perceive yourself (e.g. introversion/extroversion) and any interpersonal patterns you may be aware of (e.g. "I tend to fall in love too easily" or "I tend to be very guarded and have a hard time trusting others").

_____

_____

_____

4. What do you perceive to be your personal strengths and challenges?

_____

_____

_____

5. How would you describe your social support system (e.g. friends, social/civic groups, family, support groups, etc.)? Do you experience any concerns related to too much social activity or too little social activity?_____

_____

_____

6. Do you have any recent or past history of self-harm behavior, suicidal thoughts and/or thoughts about harming others? Any history of suicide attempts or aggressive behavior toward others?

_____

_____

Substance use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas/pop with caffeine (Coke, Pepsi, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your alcohol consumption/drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer, wine or hard liquor do you consume each week, on the average?

_____

8. Have you ever felt like you used drugs or alcohol too frequently or in a manner that caused you problems? If so, please describe:

_____

_____

_____

_____

Legal

Do you have any current legal concerns related to mental health and/or substance abuse (e.g. court requirement to attend therapy)? Are you seeking therapy as a result of a work injury or disability?

_____

_____

Medical History

1. Starting with your childhood and proceeding up to the present, please list *all important* diseases, illnesses, accidents and
injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Please list any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. Please list *all* medications, drugs, or other substances you currently take:

Medication/drug	Dose	Taken for	Prescribed and supervised by

Developmental History

1. Please list any concerns, difficulties or delays you experienced in meeting developmental milestones, such as walking, speaking, reading, toilet training, etc. Please also note any history of advanced maturation or early milestone achievement, such as early graduation and grade advancement while in school.

_____

_____

_____

Health Habits

1. What kinds of physical exercise do you participate in?

_____

_____

_____

2. Do you try to restrict your eating in any way?

How? _____

Why? _____

3. Do you take any vitamins or supplements? If so, please list them here and your reasons for taking them. I'm particularly interested in knowing which supplements you take to improve or adjust your mood.

_____

_____

4. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems? _____

_____

_____

For women

Please describe any concerns or personal history regarding your menstrual cycle (e.g. hormonal imbalance, fertility concerns, early menstruation, menopause, etc.):

_____

_____

_____

Have you ever been pregnant? If yes, how many pregnancies have you experienced? Have you experienced any difficulties related to pregnancy and/or childbirth that concern you now? Any history of post-partum depression or loss of pregnancy?

_____

_____

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_____

Healthcare Coordination

Would you like me to coordinate with other healthcare providers (such as: primary care physician, psychiatrist, couples therapist, group therapist, etc.)? If yes, please indicate whom I should coordinate treatment with.

_____

_____

Other

Is there anything else that I should know? _____

_____

_____

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