INITIAL ASSESSMENT

Today's Date: _____

IDENTIFYING INFORMATION

Client's Name: _____ D.O.B. ____/____/____ Gender _____

Ethnicity _____ Language Preference _____ Highest Education level _____

Phone: _____ email address: _____

Address: _____

Current Employment *(work duties, location, how long in position)*:_____

_____

Relationship status *(single, long term relationship, married, living together, separated):* _____

Children (*list names, ages, living situation*)

_____

_____

Other adults in home: *(list name, relationship, time living in the home)*

_____

_____

Emergency Contact: Name/Relation: _____ Phone: _____

Are you involved in any litigation (*lawsuits, divorce, child custody, court proceedings, personal injury*) or may be in the future?

_____

THERAPY INFORMATION:

Who referred you? _____

Previous Counseling: _____

Purpose for seeking therapy(*What do you want to get from therapy?)* _____

_____

PRESENTING CONCERNS:

Please identify any concerning symptoms listed below:

Allergies	Chronic Pain	Grieving	Irritable	Migraines	Relationship issues	Stress
Anger/Rage	Compulsions	Fearful	Intestinal problems	Nightmares	Restless	Suicidal
Anorexia	Crying Spells	Headaches	Isolation	Obsessions	School problems	Tension
Anxiety	Delusions	Hallucinations	Legal problems	Overeating	Self-doubt	Trauma
Appetite changes	Depression	Hyperactivity	Low energy	Panic attacks	Sexual difficulties	Unfocused
Asthma	Domestic violence	Indecisive	Low motivation	Peer difficulties	Sleep problems	Work problems
Bulimia	Gender issues	Insomnia	Mood changes	Racing heart	Stomachaches	

If other, please describe: _____

_____

HEALTH HISTORY

Current physical health and any health changes Date of last physical/wellness visit: _____

_____

_____

Current medication _____

_____

Prescribing Doctor: _____

ADDICTIONS: (*detail past, present, relapse, sobriety*)

Substances such as alcohol, drugs, or smoking: _____

_____

Behavioral such as social media, shopping, pornography, gaming, gambling: _____

_____

FAMILY AND COMMUNITY SUPPORTS

Are there people in your family or community that support you? _____

Do you receive support from religious or spiritual groups? _____

STRENGTHS:

What helps you to continue during hard times? _____

_____

What resources do you need to help you reach your goals? _____

_____

Clinical Notes/(MSE):