Personal Assessment

Name: _____ Date of birth: _____ Age: _____

Preferred name:_____

Address: _____
street number and name city state ZIP code

Phone: _____ Email: _____

May we leave a message at this number? Yes No

Would you like a text reminder of your appointments? Yes No

To whom should bills be sent: _____

Billing address, if different from above: _____

Insurance company: _____

Emergency contact/Phone: _____Relationship: _____

Primary physician: _____

Medications: _____

Have you ever been in therapy? Yes No If yes, when:_____

Outcome _____

Relationship status: Single Married Separated/Divorced Partners

List all household members and their relationship to you:

Persons	Relationships

Please describe current problems:

- ☐ Anxiousness
- ☐ Appetite disruption
- ☐ Child management
- ☐ Decreased energy
- ☐ Delusions
- ☐ Depressed mood
- ☐ Disruption of thoughts
- ☐ Dissociation
- ☐ Elevated mood
- ☐ Financial
- ☐ Guilt
- ☐ Hallucinations
- ☐ Homicidal
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impaired concentration
- ☐ Impaired memory
- ☐ Impulsiveness
- ☐ Irritability
- ☐ Manic
- ☐ Relational
- ☐ Obsessions or compulsions
- ☐ Occupational
- ☐ Oppositional
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Phobias
- ☐ Physical complaints
- ☐ Police contact
- ☐ Poor judgment
- ☐ School/home/ community issues
- ☐ Self-injury
- ☐ Sexual issues
- ☐ Sleeplessness
- ☐ Substance use
- ☐ Suicidal
- ☐ Tearful
- ☐ Violence
- ☐ Worthlessness
- ☐ Other: _____
  _____
  _____
  _____

_____ _____

Highest grade completed: _____ High school diploma?: _____ GED or HSED? _____

College degree?: Associates Bachelor's Advanced degree

Employment status: Employed Unemployed Disabled

Current employer: _____ How long: _____

Have you been a victim of abuse? Yes No If yes: Physical Sexual Emotional

Please describe history of abuse (include information as victim, perpetrator, or affected family member):
_____
_____
_____

Have you had any psychiatric hospitalizations? Yes No If yes, when/describe:
_____
_____

Do you have a history of alcohol or drug abuse? Yes No

Do you currently use: Alcohol Drugs (please list):_____

Do you think that you have a substance abuse problem? Yes No

1. In addition to the symptoms listed, please let us know of any other physical problems or health concerns you may have: _____
_____
_____

2. Describe any significant life events that may be affecting you currently. For example, loss of a family member, divorce, poverty, homelessness, etc. _____
_____
_____

3. What are your goals for counseling? _____
_____
_____

4. What are your strengths? _____
_____
_____

5. Is there anything else you would like your therapist to know about you? _____
_____

I certify that I have answered all questions honestly to the best of my knowledge.

Client signature: _____ Date: _____