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CLIENT SELF-ASSESSMENT

Thank you in advance for taking the time to fill out this form. Answer as honestly and as completely as you can. .

Date:_____ How did you learn about me?_____
Name: _____Middle Initial:_____ Last Name:_____
Date of Birth: _____ Age: _____ Race/Ethnicity:_____
Sexual Preference:_____ Gender Identity: _____
Current Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____ County: _____
Where you raised?_____

Phone #: (_____) _____ OK to leave message, text? _____ Please initial _____
Alternate Phone #: (_____) _____ OK to Text? _____ Please initial _____
Email address:_____

Marital Status (please circle): Child Married Separated Divorced Widowed Never Married Cohabiting
Date of Marriage: _____ Spouse's Name:_____
How many marriages/significant relationships? _____
Please list any previous significant relationship(s) start/end dates.
_____
_____
_____
_____

Please list **children**, their ages, and whether currently living with you.
_____
_____
_____

Please list **siblings'** names and ages, and if they live nearby.
_____
_____
_____
_____

If in school, please give name of school and grade.
_____

SITUATION PROMPTING COUNSELING

What is the reason for coming to counseling? Why now, instead of another time?
_____
_____
_____

Check any of the following symptoms that apply to you right now:
____ depression ____fatigue, decreased activity ____financial problems
____sleep problems- too much, ____relationship problems ____work/career problems

too little (circle)
___sexual difficulties
___eating/appetite problems- too much, too little (circle)
___hopelessness/helplessness
___infidelity of partner
___suicidal, self-harm thoughts
___personal infidelity
___life transition issues
___anxiety
___family issues
___spirituality issues
___chest pain/discomfort
___health issues
___past sexual abuse
___shortness of breath
___chronic pain
___ grief
___addiction to _____
___other issue _____

Have you ever sought counseling before? _____ When? _____
With whom?_____Was it helpful? _____

HEALTH / SUBSTANCE ABUSE HISTORY

Name of **Psychiatrist,** if applicable, and date last seen: _____
When did you first see a psychiatrist? _____
If you have ever been given a **psychiatric diagnosis**, what is it? _____
List prescription and over-the-counter **medications y**ou are currently taking:
_____
_____
_____
_____

Please list any **family history of emotional or mental illness**. What problems were experienced, and by which family members? _____
_____

Have you been hospitalized for **emotional or drug/alcohol problems**? Please list when and where.
_____
_____
If you have any **significant health issues,** please list what and when it began:
_____
_____
_____

Have you had any problem, past or present, with **drugs/alcohol**? _____
If you have you been affected by someone else's drug/alcohol problem, please explain.
_____
_____

SOCIAL HISTORY

Highest level of **education** completed: _____
Employed? _____**Occupation**:_____Years on the job/in the field:_____
Are you on **disability**? _____ If yes, what type, & when was it awarded? _____

How would you rate your **social life**?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, satisfying)
How would you rate your **work satisfaction**?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, satisfying)

How would you rate your current **relationship with your spouse** or significant other?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive)

How would you rate your current **relationship with Mother**? Is she living, and how old? _____
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive)

How would you rate your current **relationship with Father**? Is he living, and how old? _____
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive)

How would you rate your current **relationship(s) with your children**?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive)

How would you rate your current relationship(s) with your **siblings**?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive)

How important is your **faith** or spirituality in your life?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive)

If you have a faith or higher power, who/what is it? _____
Do you have any current or pending **legal problems**?_____
Please point out to me if you have any **child custody issues**._____

Have you ever been on **probation/parole**? _____ DWI/DUI? _____When? _____
If so, please explain._____
_____
Were you raised in a **military family**, are you currently serving, or have you served in the military?_____
Which branch and when? _____ Thank you for your service.
Are you currently sexually active? _____ Are sexual issues, past or present, any part of why you're here? ____

What is your **biggest fear**? _____

What **losses, traumas, or transitions** have significantly impacted your life (e.g. divorce, arrests, job changes, death breakups, etc.)? What age were you when these changes occurred?
_____
_____

Who is supportive of you, who can you count on (family, friends, church etc.)?
_____
_____

What are your **goals**, what do you hope to accomplish by coming to therapy? What do you see as your part in our working relationship?
_____
_____

Signature _____ Date _____

Thank you.
Pamela Salaam, LCSW