



**INITIAL ASSESSMENT**

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Your reason for seeking counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anyone you want involved in your counseling? (ex: spouse, pastor, teacher, etc.) \_\_\_\_\_  
\_\_\_\_\_

**EMPLOYMENT HISTORY**

Current Employer \_\_\_\_\_ Length of employment \_\_\_\_\_

Position/Title \_\_\_\_\_ Job satisfaction \_\_\_\_\_

**EDUCATIONAL HISTORY**

Highest grade completed? \_\_\_\_\_ Name of school \_\_\_\_\_

Area of study \_\_\_\_\_ Do/did you like school?  Yes  No Explain \_\_\_\_\_

Describe school performance \_\_\_\_\_

Have you ever been diagnosed with a learning disability?  Yes  No Explain \_\_\_\_\_

Have you ever been diagnosed with ADD/ADHD?  Yes  No

**MILITARY HISTORY**

Were you in the military service? Branch \_\_\_\_\_ Enlisted? \_\_\_\_\_ Drafted? \_\_\_\_\_

Tour \_\_\_\_\_ Dates Served \_\_\_\_\_ Combat  Yes  No Stationed \_\_\_\_\_

Disability or pension \_\_\_\_\_ Type of discharge \_\_\_\_\_

**LEGAL SYSTEM INVOLVEMENT**

Yes No

Have you ever been involved with the legal system?  Yes  No If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MARITAL/RELATIONSHIP HISTORY**

Current Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ Length of Relationship \_\_\_\_\_

Were you previously married?  Yes  No Was your spouse?  Yes  No

Name	Age	Relationship (indicate child/stepchild/adopted)	Lives with you?
		<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> child <input type="checkbox"/> stepchild <input type="checkbox"/> adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No

**FAMILY HISTORY**

Father's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Education \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Education \_\_\_\_\_ Occupation \_\_\_\_\_

Marital status of parents: \_\_\_\_\_

Step Father's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Education \_\_\_\_\_ Occupation \_\_\_\_\_

Step Mother's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Education \_\_\_\_\_ Occupation \_\_\_\_\_

Where were you born? \_\_\_\_\_ Who raised you? \_\_\_\_\_  
 Were you adopted?    Yes    No   If yes, at what age? \_\_\_\_\_

**BROTHER'S & SISTER'S**   (full or step or half)

Name	Age	Occupation	Marital Status

**FAMILY HISTORY (cont)**

Have you or any member of your family experienced any of the following?   (check all that apply)

**ADDICTIONS**

- Alcohol: Who? \_\_\_\_\_
- Drugs: Who? \_\_\_\_\_
- Food/Eating: Who? \_\_\_\_\_
- Gambling: Who? \_\_\_\_\_
- Sex/Pornography: Who? \_\_\_\_\_
- Relationship/Love: Who? \_\_\_\_\_
- Other \_\_\_\_\_ Who? \_\_\_\_\_

**EMOTIONAL PROBLEMS**

- Depression: Who? \_\_\_\_\_
- Anxiety: Who? \_\_\_\_\_
- Panic Attacks: Who? \_\_\_\_\_
- Manic/Depression: Who? \_\_\_\_\_
- Obsessions: Who? \_\_\_\_\_
- Suicide attempts or completion: Who? \_\_\_\_\_
- Phobia/fears: Who? \_\_\_\_\_
- Anger/Explosive: Who? \_\_\_\_\_
- Other: Who? \_\_\_\_\_

Have you or any member of your family been hospitalized for any of the above?  Yes  No

If yes, Who? \_\_\_\_\_

**ABUSE: (to self/family member)**

- Physical: Self/Family? \_\_\_\_\_ by whom? \_\_\_\_\_
- Emotional: Self/Family? \_\_\_\_\_ by whom? \_\_\_\_\_
- Sexual: Self/Family? \_\_\_\_\_ by whom? \_\_\_\_\_
- Spiritual: Self/Family? \_\_\_\_\_ by whom? \_\_\_\_\_

Did you ever witness violence in your home or elsewhere while growing up?  Yes  No If yes, explain \_\_\_\_\_

**PHYSICAL, PSYCHOLOGICAL AND SOCIAL HISTORY**

Physicians's name \_\_\_\_\_ Name of Practice \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

List any current or past medical conditions \_\_\_\_\_

List any surgeries and dates \_\_\_\_\_

List all current medications (dosage, frequency and purpose) \_\_\_\_\_

List any allergies \_\_\_\_\_

List past use of medications for depression, anxiety, ADD/ADHD, sleep, weight control, smoke cessation, etc.? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much and how often? \_\_\_\_\_

Do you smoke cigarettes or chew tobacco?  Yes  No If yes, how much and how often? \_\_\_\_\_

Do you consume caffeine?  Yes  No If yes, how much and how often? \_\_\_\_\_

**CURRENT SYMPTOM CHECKLIST:**

**Are you currently experiencing any of the following? Please Check**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Anger                     | <input type="checkbox"/> Bad dreams/nightmares | <input type="checkbox"/> Compulsive Behaviors   |
| <input type="checkbox"/> Crying often        | <input type="checkbox"/> Depression                | <input type="checkbox"/> Easily Annoyed        | <input type="checkbox"/> Violent Thoughts       |
| <input type="checkbox"/> Mood Swings         | <input type="checkbox"/> Loneliness                | <input type="checkbox"/> Loss of Hope          | <input type="checkbox"/> Trouble Managing Money |
| <input type="checkbox"/> Obsessive Thoughts  | <input type="checkbox"/> Problems in Relationships | <input type="checkbox"/> Weight Loss or Gain   | <input type="checkbox"/> Racing Thoughts        |
| <input type="checkbox"/> Sexual problems     | <input type="checkbox"/> Panic Attacks             | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Trouble Sleeping       |
| <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Work Problems             | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> School Problems        |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Low Self Esteem           | <input type="checkbox"/> Social Withdrawal     | <input type="checkbox"/> Backaches              |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Restlessness              | Other: _____                                   |   |

**Describe any losses that you have experienced (i.e. health issues, death, divorce, pregnancy loss, retirement, moves, etc.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS COUNSELING**

**Have you ever had formal counseling?**  Yes  No **How many times?** \_\_\_\_\_

**With whom?** \_\_\_\_\_

**When?** \_\_\_\_\_

**Why?** \_\_\_\_\_

**Was it inpatient or outpatient?** \_\_\_\_\_

**Was it helpful?**  Yes  No **Explain** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Describe the last major change in your life** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**HISTORY**

**Do you have people in your life that you consider close friends?**  Yes  No

**When going through a difficult experience in your life do you have someone to confide in?**  Yes  No

**What activities/hobbies do you enjoy participating in?** \_\_\_\_\_

**Are you a member of any groups or organizations?**  Yes  No **Explain** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**List two strengths about yourself** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**List two things about yourself that you would like to change?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SPIRITUAL HISTORY**

Are you affiliated with a church?  Yes  No

If yes, which church? \_\_\_\_\_ Pastor's name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

How involved are you in the congregation? \_\_\_\_\_

Attendance:  Never  Sometimes  Regularly

**ADDITIONAL INFORMATION**

What else should your therapist know about you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapist \_\_\_\_\_

Date of assessment review \_\_\_\_\_