Name: _____

Date: _____

Self-Assessment

(Please complete both sides)

What is happening in your life which resulted in this appointment?

_____

_____

_____

What would you like to see accomplished in therapy?

_____

_____

_____

CURRENT CHIEF COMPLAINT

(CHECK ALL THAT APPLY TO YOU)

__ Depression
__ Low energy/fatigue
__ Low self-esteem
__ Poor concentration
__ Hopelessness
__ Worthlessness
__ Guilt
__ Feelings of emptiness
__ Sleep disturbance (more/less)
__ Appetite disturbance (more/less)
__ Aggressive behaviors
__ Thoughts of hurting someone
__ Isolation/social withdrawal
__ Sadness/loss
__ Loneliness
__ Stress/anxiety
__ Panic attacks
__ Heart pounding/racing
__ Chest pain
__ Trembling/shaking
__ Sweating/chills/hot flashes
__ Tingling/numbness
__ Fear of dying
__ Fear of going crazy
__ Nausea/stomach problems
__ Phobias
__ Headaches
__ Nightmares
__ Chronic Pain
__ Obsessions/compulsive behaviors
__ Thoughts racing/can't hold onto an idea
__ Eating Problems (binge/purge/obesity)
__ School/work problems
__ Excessive or impulsive behaviors
__ Delusions/hallucinations
__ Not thinking clearly/confusion
__ Difficulty trusting others
__ Feeling that you/things around you are not real
__ Lose track of time
__ Unpleasant thoughts won't go away
__ Anger/frustration management problems
__ Easily agitated/annoyed
__ Defies rules/blames others
__ ADHD symptoms
__ Argues excessively
__ Excessive use of drugs and/or alcohol
__ Excessive use of prescription medications
__ Gambling or other addiction _____
__ Alcohol blackouts
__ Flashbacks (not drug related)
__ Domestic violence issues
__ Relationship, marital or family problems
__ Sexual problems
__ Sexual or physical abuse or neglect issues
__ Other trauma history (accident, fire, etc.)
__ Suicidal thoughts/actions (circle)
__ Self-harm thoughts/actions (circle)
__ Fears of abandonment/rejection
__ Codependency issues
__ Other problems/symptoms: _____

Previous therapy?

With: _____ _____

Helpful? Yes ___ No ___ Some ___ Comments _____

_____

Medications, list current:_____

Helpful? Yes __ No __ Some ___ Comments _____

Medications, list past: _____

Helpful? Yes __ No __ Some __ Comments _____

Previous psychiatric hospitalization? Yes _ No __

Number of hospitalizations _____

If yes, when _____

Previous residential/out of home placement? Yes__ No __

If yes, when _____

Family History of Psychiatric/Emotional/Behavioral problems: _____

_____

_____

_____

Last medical exam: _____

List any medical problems that you are currently experiencing:

_____

_____

List any significant medical problems that you have previously experienced:

_____

_____

_____

Any other relevant information:

_____

_____

_____

_____