**Self-Assessment**

Name ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is happening in your life that resulted in this appointment being made? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What would you like to see accomplished in counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Chief complaint and duration (check all that apply to you):**

SymptomDuration Symptom Duration

\_\_\_ Aggressive \_\_\_\_\_\_\_\_\_\_

\_\_\_ Anxiety \_\_\_\_\_\_\_\_\_\_

\_\_\_ Anger/frustration \_\_\_\_\_\_\_\_\_\_

\_\_\_ Appetite disturbance (more/less) \_\_\_\_\_\_\_\_\_\_

\_\_\_ Arguing \_\_\_\_\_\_\_\_\_\_

\_\_\_ Blackouts \_\_\_\_\_\_\_\_\_\_

\_\_\_ Can’t hold onto an idea \_\_\_\_\_\_\_\_\_\_

\_\_\_ Chest pain \_\_\_\_\_\_\_\_\_\_

\_\_\_ Chills/hot flashes \_\_\_\_\_\_\_\_\_\_

\_\_\_ Confusion/Not thinking clearly \_\_\_\_\_\_\_\_\_\_

\_\_\_ Depression \_\_\_\_\_\_\_\_\_\_

\_\_\_ Defiance of rules \_\_\_\_\_\_\_\_\_\_

\_\_\_ Delusions/Hallucinations \_\_\_\_\_\_\_\_\_\_

\_\_\_ Destroys property \_\_\_\_\_\_\_\_\_\_

\_\_\_ Enuresis (wets)/Encopresis Soils) self \_\_\_\_\_\_\_

\_\_\_ Excessive use of drugs \_\_\_\_\_\_\_\_\_\_

\_\_\_ Excessive use of alcohol \_\_\_\_\_\_\_\_\_\_

\_\_\_ Excessive use of prescription medication \_\_\_\_

\_\_\_ Excessive behavior (spending, gambling, sex) \_\_

\_\_\_ Easily agitated/annoyed \_\_\_\_\_\_\_\_\_\_

\_\_\_ Fear of dying \_\_\_\_\_\_\_\_\_\_

\_\_\_ Fear of going crazy \_\_\_\_\_\_\_\_\_\_

\_\_\_ Feeling like you are not real \_\_\_\_\_\_\_\_\_\_

\_\_\_ Feeling like things around you are not real \_\_\_\_

\_\_\_ Guilt \_\_\_\_\_\_\_\_\_\_

\_\_\_ Hurts animals \_\_\_\_\_\_\_\_\_\_

\_\_\_ Hopelessness \_\_\_\_\_\_\_\_\_\_

\_\_\_ Heart pounding/racing \_\_\_\_\_\_\_\_\_\_

\_\_\_ Helplessness \_\_\_\_\_\_\_\_\_\_

\_\_\_ Inappropriate sexual behavior \_\_\_\_\_\_\_\_\_\_

\_\_\_ Isolation/Social withdrawal \_\_\_\_\_\_\_\_\_\_

\_\_\_ Lies \_\_\_\_\_\_\_\_\_\_

\_\_\_ Lose track of time \_\_\_\_\_\_\_\_\_\_

\_\_\_ Low energy \_\_\_\_\_\_\_\_\_\_  
\_\_\_ Low self-esteem \_\_\_\_\_\_\_\_\_\_

\_\_\_ Obsessive/compulsive behaviors \_\_\_\_\_\_\_\_\_\_

\_\_\_ Nausea \_\_\_\_\_\_\_\_\_\_

\_\_\_ Panic attack \_\_\_\_\_\_\_\_\_\_

\_\_\_ Phobia \_\_\_\_\_\_\_\_\_\_

\_\_\_ Plays with fire \_\_\_\_\_\_\_\_\_\_  
\_\_\_ Poor concentration \_\_\_\_\_\_\_\_\_\_

\_\_\_ Poor eye contact \_\_\_\_\_\_\_\_\_\_  
\_\_\_ Physical abuse issues \_\_\_\_\_\_\_\_\_\_

\_\_\_ Runs away \_\_\_\_\_\_\_\_\_\_  
\_\_\_ Spousal abuse issues \_\_\_\_\_\_\_\_\_\_

\_\_\_ Sexual abuse issues \_\_\_\_\_\_\_\_\_\_  
\_\_\_ School refusal \_\_\_\_\_\_\_\_\_\_

\_\_\_ Sleep disturbance (more/less) \_\_\_\_\_\_\_\_\_\_

\_\_\_ Stress \_\_\_\_\_\_\_\_\_\_

\_\_\_ Sadness/Loss \_\_\_\_\_\_\_\_\_\_

\_\_\_ Sweating \_\_\_\_\_\_\_\_\_\_

\_\_\_ Thoughts of hurting someone else \_\_\_\_\_\_\_\_\_\_

\_\_\_ Thoughts racing \_\_\_\_\_\_\_\_\_\_

\_\_\_ Thoughts of hurting yourself \_\_\_\_\_\_\_\_\_\_

\_\_\_ Tingling/numbness \_\_\_\_\_\_\_\_\_\_

\_\_\_ Trembling/shaking \_\_\_\_\_\_\_\_\_\_

\_\_\_ Unpleasant thoughts won't go away \_\_\_\_\_\_\_\_

\_\_\_ Worthlessness \_\_\_\_\_\_\_\_\_\_

\_\_\_ Other problems/symptoms (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify other or explain anything from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Previous outpatient therapy with whom and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list all medications and reason for taking them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list all hospitalization dates and reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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