Self Assessment

Name: _____ Date: _____

What is happening in your life that results in this appointment? _____

_____

_____

How long have you had these concerns? _____

How have you attempted to deal with your concerns? _____

_____

CHECK ALL OF THE COMPLAINTS LISTED BELOW THAT APPLY TO YOU

☐ Depression	☐ Starting too many projects, finishing none	☐ Easily angered
☐ Low / Loss of energy	☐ Stress/Tension	☐ Easily agitated/Frustrated
☐ Low self-esteem	☐ Anxiety/Panic	☐ Obsessive/Compulsive behaviors
☐ Poor concentration	☐ Heart pounding/Racing	☐ Following or stalking someone
☐ Hopelessness	☐ Chest pain	☐ Excessive use of drugs or alcohol
☐ Sadness	☐ Trembling/Shaking	☐ Blackouts / Loss of time
☐ Guilt	☐ Sweating	☐ Excessive behaviors (gambling, spending)
☐ Shame	☐ Chills/Hot flashes	☐ Physical abuse
☐ Worthlessness	☐ Tingling/Numbness	☐ Sexual abuse
☐ Fear of dying	☐ Racing thoughts	☐ Emotional abuse
☐ Persistent and/or unpleasant thoughts	☐ Hallucinations	☐ Domestic violence
☐ Death of family member, spouse, or friend	☐ Problematic fears	☐ Trouble falling /Staying asleep
☐ Appetite disturbance (more or less?)	☐ Confusion	☐ Nightmares/Bad dreams
☐ Sleep disturbance (more or less?)	☐ Blame others	☐ Work problems
☐ Feeling disconnected from self / things	☐ Defy rules	☐ Social problems
☐ Isolation/Social withdrawal	☐ Argumentative	☐ Family problems

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Are you currently having thoughts of self-harm? ____Yes ____No If yes, please describe what your intentions are:_____

Are you currently having thoughts of harming someone else? ____Yes ____No If yes, please describe what your intentions are:_____