Life Transitions Counseling

Background Info & Self-Assessment

Client Name:

Date: Age: Marital Status: Gender:

Did another professional recommend that you or members of your family come to therapy? If yes, who?

What concerns/issues have brought you to the office today?

Who is living in your residence with you?

Name Age Relationship

Children not living at home full time?

Name Age

Do you have any medial concerns, surgeries or hospitalizations either current or past? If yes, please list:

Condition Treating Physician

Are you currently taking medication? If yes, please list:

Medication Dosage Condition Physician

Do you have any Allergies? If yes, please list:

Primary Care Doctor/Referring physician: Phone: ( )

Last physical exam:

Family History - Have you (or any biological family members) had a history of:

Mental Illness: Y N if yes: ___ myself ____ Family member Relationship _____

Condition(s):

Substance Abuse? Y N if yes: ___ myself ____ Family member Relationship _____

Medical Illness? Y N if yes: ___ myself ____ Family member Relationship _____

Suicidal Thoughts? Y N if yes: ___ myself ____ Family member Relationship _____

Self Harm Attempts? Y N if yes: ___ myself ____ Family member(s) Relationship _____

Self-Injurious Behaviors? When:

Homicidal Thought? When:

Abuse History:

Physical? Y N If yes, Age: Abuser:

Sexual? Y N If yes, Age: Abuser:

Emotional? Y N If yes, Age: Abuser:

Current use of:

Alcohol: Y N If yes, How Often: Amount:

Drugs: Y N If yes, How Often: Amount:

Other Addictive Behaviors (gambling ,shopping, internet, sex) Y N Type:

Current Symptoms:

check all that apply and indicate duration of symptoms

		Length of Time
☐	Depressed	
☐	Sad	
☐	Hopeless	
☐	Worthless	
☐	Helpless	
☐	Overly guilty	
☐	Lack of interest in things you used to enjoy	
☐	Anxious or have difficulty controlling worry	
☐	Phobias	
☐	Fidgety or trouble sitting still	
☐	Tired, in slow motion or worn out	
☐	Unable to think through problems or concentrate	
☐	Stress	
☐	Heart pounding/racing	
☐	Chest pain	
☐	Trembling/shaking	
☐	Sweating	
☐	Nausea	
☐	Anger/frustration	
☐	Isolation/social withdrawal	
☐	Feelings of loss	
☐	Argumentative	
☐	Easily agitated	
☐	Obsessions/compulsive behaviors	
☐	Confusion	

		Length of Time
	Change of Appetite	
☐	Gain	
☐	Loss	
	Sleeping Changes	
☐	o Difficulty Falling Asleep	
☐	o Waking up during the night	
☐	o Getting up earlier than you want	
☐	o Sleeping more than wanted	
☐	Persistent unpleasant thoughts	
☐	Thoughts of hurting yourself	
☐	Thoughts of hurting someone else	
☐	Racing thoughts	
☐	Excessive use of alcohol and/or Drugs	
☐	Excessive use of prescription drugs	
☐	Excessive behaviors	
☐	Chills/hot flashes	
☐	Fear of dying	
☐	Fear of losing control	
☐	Lose track of time/deadlines	
☐	Delusions/hallucinations	
☐	Blackouts	
☐	Feeling that you are not real	
☐	Feeling that things around you are not real	
☐	Other issues/concerns	

How long have these issues been of concern to you?

Have any of the above issues caused impairment, disruption or difficulties with social relationships, academic/work performance or other important activities?

Please Explain:

Have you had previous counseling? Y N When:

What was the duration of treatment? Was it helpful? Y N

Have there been any deaths or major changes (deployment, separations, job loss, moving) in the immediate family? If yes, Who/What: When:

TREATMENT GOALS:

What are you trying to accomplish with counseling?

Please list any concerns you have about coming to therapy