MC Wellness
LIVE WELL. DO BETTER.

Assessment and History Information

This information will help you and your therapist begin to clarify your therapy goals.

Patient Name: _____ Date: _____

☐ YES ☐ NO Have you ever been treated by a psychiatrist?
If yes, Name _____ Date of last visit_____

☐ YES ☐ NO Have you ever been hospitalized for mental/behavioral or chemical dependency treatment?
If yes, where and when?_____

☐ YES ☐ NO Have you seen another therapist in the past 24 months?
If yes, who did you see? _____
Did you find anything affective/not affective_____

☐ YES ☐ NO Have you ever attempted suicide?
If yes, when and how? _____

In the past 36 months has there been a death of a family member or someone close to you?
☐ YES ☐ NO If yes, who?:_____When: _____

Prior to the 36 months, has there been a death of a family member or someone that was close to you?
☐ YES ☐ NO If yes, who?:_____When: _____

Briefly describe your reasons for seeking counseling services: _____
_____

What kind of things have you tried so far to handle this situation? _____
_____

Fears or concerns of counseling: _____
_____

Goal or expectation of counseling: _____
_____

Any additional information you feel will assist in formulating your treatment plan and improving your ability to LIVE WELL and DO BETTER?

_____
_____
_____
_____