Initial Assessment Information

Today's Date_____

Name _____ D.O.B _____

Why are you seeking therapy at this time? _____

_____

_____

_____

Section 1: Demographics

Ethnicity: _____

Native Language: _____

Gender Identity: _____

Sexual Orientation: _____

Religious/Spiritual Affiliation: _____

Are you adopted? ☐ yes ☐ no If yes, at what age? _____

Does your family have any financial concerns? ☐ yes ☐ no If yes, describe: _____

_____

Do you, or have you ever had any legal issues? ☐ current ☐ past ☐ never Describe: _____

_____

Section 2: Family Information

Please list your family members including your parents or guardians, siblings, and anyone else you consider close family

Name	Age	Gender	Relationship to you

Please describe your current living situation _____

_____

_____

Please describe your relationship with each parent or guardian:

1) _____

_____

2)_____

_____

Please describe your relationship with your sibling(s), if applicable: _____

_____

_____

Does anyone in your family have a history of drug and/or alcohol abuse or addiction?

_____

_____

Does anyone in your family have a history of legal complications? _____

_____

Is there anything else you would like me to know about your family at this time? _____

_____

_____

Section 3: Current Concerns

Please check any symptoms you have experienced within the past month

☐Difficulty sleeping (please describe): _____

☐ Loss of interest in activities you used to enjoy ☐Difficulty getting out of bed

☐ Withdrawing from others ☐Isolation ☐Anger outbursts ☐Depressed mood

☐Difficulty leaving home ☐Feeling of numbness ☐Irritability ☐Anxiety

☐Hopelessness ☐Helplessness ☐Sadness ☐Panic ☐Fear ☐Frequent guilt

☐Racing thoughts ☐Frequent worry ☐Decreased energy ☐Worthlessness

☐Avoidance of people, places, activities, or specific things

☐Fear of certain objects or situations (please describe): _____

☐Repetitive behaviors (please describe):_____

☐Concerns with eating (please describe:) _____

☐Difficulty concentrating ☐Intrusive memories ☐Frequent nightmares

☐A feeling of being separate from your body ☐Abuse in your relationship

☐Feeling unsafe in your home ☐Relational difficulties ☐Difficulty expressing emotions

☐Difficulty saying no to others ☐Feeling out of control ☐Ineffective communication

☐Sexual concerns ☐Unusual visual or auditory experiences ☐Self-harming behaviors

☐Thoughts about harming yourself ☐Thoughts about harming someone else

☐Other (please describe): _____

Section 4: Academic History

Highest grade completed: _____

In your opinion, how would you rate your intelligence? ☐ Low ☐ Below average ☐ Average ☐ Above average ☐ Superior

In your opinion, does your school performance match your intelligence? ☐ yes ☐ no

What grades do you typically receive? _____

Have you ever been diagnosed with a learning difference? ☐ yes ☐ no If yes, describe:

_____

What are your favorite and least favorite school subjects? _____

_____

Section 5: Social History

Do you have few friends or many? _____

Do your friendships tend to be quick or long-lasting? _____

Do you make friends easily or is it difficult?_____

Please describe your relationship status: _____

_____

Have you ever been bullied? ☐ yes ☐ no If yes, describe: _____

_____

Have you ever bullied someone else? ☐ yes ☐ no If yes, describe: _____

_____

Section 6: Mental Health History

If applicable, please describe any past mental health treatment below? (e.g. outpatient counseling, hospitalizations, drug/ alcohol rehabilitations or residential therapeutic programs):

_____

_____

_____

Are you currently prescribed any medications by a psychiatrist? ☐ yes ☐ no

If yes, please complete the following chart:

Medication	Dose	Start Date	Condition Treated

Have you recently stopped taking any psychoactive medications? ☐ yes ☐ no

If yes, please describe: _____

Section 7: Substance Use

If applicable, describe your use of each of the following. Please include age at first use, time of most recent use, heaviest use, current use, and routes of administration.

Caffeine: _____

_____

Nicotine: _____

_____

Alcohol: _____

_____

Marijuana: _____

_____

Hallucinogens (LSD, Mushrooms, PCP, etc): _____

_____

Stimulants (Cocaine, Crack, Methamphetamine, etc): _____

_____

Depressants (Heroin, Oxycontin, benzodiazepines, etc): _____

_____

Other substances not yet mentioned: _____

_____

Do you think you have a problem with drugs and/or alcohol? ☐ yes ☐ no

Have others in your life expressed worry about your use of drugs or alcohol? ☐ yes ☐ no

Has your use of drugs or alcohol negatively impacted your relationships, academics, or other areas of your life? ☐ yes ☐ no If yes, describe:_____

_____

Section 8: Physical Health

How would you describe your physical health? ☐ Poor ☐ Below Average ☐ Average ☐ Good ☐ Excellent

List any current medical conditions or concerns: _____

_____

_____

Allergies: _____

Do you have any concerns with your nutritional or exercise habits? ☐ yes ☐ no

Describe: _____

_____

Section 9: Trauma History:

Are there any events or relationships that you have experienced as traumatic in your life? ☐ yes ☐ no

If you answered yes and you feel comfortable doing so at this time, please describe:

_____

_____

If you answered yes, are you interested in addressing your trauma(s) in therapy? ☐ yes ☐ no

Section 10: Personal Strengths

What do you see as your strengths? _____

_____

What activities do you participate in and/or enjoy?_____

_____

Describe your support network: _____

_____

Is there any other information you would like me to know at this time? _____

_____

_____