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Initial Clinical Assessment

Please note: Information provided on this form is protected as confidential information.

Personal Information:

Client Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell/Other Phone: _____ May we text or leave a message? Yes No

Email: _____ May we leave a message? Yes No

**Please note: Email or texting correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____ Gender: _____

Marital Status: Never Married Domestic Partnership Married

Separated Divorced Widowed

Referred By (if any): _____

Reason you are seeking treatment:

Areas of your life it is affecting:

Household members, age and relationship:

Suicidal risk? Denies Ideas Plans Hx of attempts Hx in family

Homicidal risk? Denies Ideas Plans Hx of attempts Hx in family

Self-Mutilation? Denies Ideas Plans Hx of attempts Hx in family

Other risk-taking behaviors:

Denies Speeding Unprotected sex Gang affiliations Violence Fire setting

Steps taken to address urgent needs:

History:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Yes No previous therapist/practitioner: _____

What was your diagnosis: _____

Did your previous treatment help? Yes No

What did you learn from your previous treatment?

When and where was your previous treatment? Inpatient or outpatient?

General and Mental Health Information:

1. How would you rate your current physical health?

Poor Satisfactory Good Very

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

Poor Satisfactory Good Very

Please list any specific sleep problems you are currently experiencing: None

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems:

None _____

5. Are you currently experiencing overwhelming sadness, grief or depression?

Yes No If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias?

Yes No If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes No

If yes, please describe: _____

8. How many times per week do you drink alcohol? _____ When you do drink, what

type of beverage do you drink, and how much? _____

9. How often do you engage in recreational drug use?

Daily Weekly Monthly Occasionally Never

10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____

11. What are the biggest challenges you have with your personal relationship?

12. What significant life changes or stressful events have you experienced recently?

13. Who is your primary care physician (name, phone and address):

Has client ever had problems with:

Seizure/epilepsy	Y N _____	Drug Abuse	Y N _____
Diabetes	Y N _____	Heart Problems	Y N _____
Lung Disease	Y N _____	Thyroid Disease	Y N _____
Tuberculosis	Y N _____	Kidney Disease	Y N _____
High Blood Pressure	Y N _____	Anemia	Y N _____
Hepatitis	Y N _____	Trouble with seeing	Y N _____
STDs	Y N _____	Trouble Hearing	Y N _____
Head Injury	Y N _____	Chronic Pain	Y N _____
Alcohol Abuse	Y N _____	Asthma	Y N _____

Medical Hospitalizations client has had in the past? (Surgeries, Illness, accidents, etc.)

Reason	Date
_____	_____
_____	_____
_____	_____

Current Medications (Including prescription, over the counter or herbal medicines)

Name of Medicine	Dose	Given for
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to food, medications or other things? [] Y [] N _____

Family Mental Health History:

In the section below identify if there is a family history **or if you have any issues** with any of the following. If yes, please indicate the family member's relationship to you (father, maternal grandmother, paternal uncle, etc.).

Alcohol/Substance Abuse: yes/no _____

Anxiety: yes/no _____

Depression: yes/no _____

Bipolar Disorder: yes / no _____

Domestic Violence: yes/no _____

Eating Disorders: yes/no _____

Obesity: yes/no _____

Obsessive Compulsive Behavior: yes/no _____

Schizophrenia: yes/no _____

Suicide Attempts: yes/no _____

Homicide or Attempts: yes / no _____

Sexual Abuse of client or other family members yes/no _____

Please check all of the behaviors and symptoms that you consider a problem:

- | | | |
|---|--|--|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Withdrawal from | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Boredom | people | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Seasonal mood | <input type="checkbox"/> Specific fears | <input type="checkbox"/> Computer addiction |
| changes | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Pornography problems |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Loss of | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Sexual problems |
| pleasure/interest | <input type="checkbox"/> Aggression/fights | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Self-harm | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Recurring bad |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Flashbacks | memories or nightmares |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Hearing voices | |
| <input type="checkbox"/> Low self-worth | <input type="checkbox"/> Visual hallucinations | |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Suspicion of others | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Racing thoughts | |

Additional Information:

1. Are you currently employed? Yes No

If yes, who is your current employer? _____

Do you enjoy your work? Yes No

Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief and place of worship, if applicable:

3. Where were you born and raised?

4. Describe the family who raised you: (how many siblings, quality of relationships):

5. Describe current family relationships: (significant other? children? quality of relationships?):

6. Describe past significant relationships (marriages, divorces, separations, etc.):

7. Describe any significant losses/separations of any family members/significant others (including loss of pets, physical functions, property/possessions, etc.):

8. Describe current housing situation (house, mobile home, boarding homes, shelter, homeless, etc.): Any needs?

9. Any problems/issues/changes with sex/sexuality?

10. Describe current social involvement (activities that you enjoy with others):

11. Describe current spiritual/religious involvement:

12. Describe educational background (how far in school, tech school, college, special ed., special programs, highest level completed):

13. History of legal involvements, as well as any current legal problems:

14. Have you experienced any past traumas? (sexual, accidents, domestic violence, ...)

15. What would you like to accomplish out of your time in therapy?

16. How will you or your life be different when you are ready for discharge from therapy? Complete this sentence...

I will be ready for discharge when... _____

Strengths, Needs, Abilities and Preferences:

Strengths: (Family, social, spiritual & hobbies that have helped overcome past crises):

Needs: (Client's expression of current needs: emotional, physical & environmental):

Abilities: Client's ability to follow up with treatment _____(yes/no), Client understands instructions & is willing to participate in treatment _____(yes/no).

Preferences: Appointment day/evening (circle).

Are you currently seeking treatment from another provider: Yes/No

MENTAL STATUS				
<i>Affect</i>	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Blunted	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat <input type="checkbox"/> Labile
<i>Appearance</i>	<input type="checkbox"/> Well-groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate	
<i>Attitude</i>	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Uncooperative	
<i>Mood</i>	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Euphoric
<i>Motor Activity</i>	<input type="checkbox"/> Calm	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated	<input type="checkbox"/> Tremors/Tics
<i>Thought Process</i>	<input type="checkbox"/> Intact	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Tangential	<input type="checkbox"/> Loose assoc.
<i>Thought Content</i>	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	
<i>Orientation</i>	<input type="checkbox"/> Fully oriented	Disoriented as to: <input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person		

Diagnosis:

Criteria for Diagnosis:
