

Self Assessment

In filling out this form you are welcome to provide as much information as you would like. If you find a question that you desire to leave blank, you are welcome to do so for any reason. Your counselor will review this form and if they have any questions regarding your answers, they will follow up with you in session. Thank you.

Section A: Client Information

Client Name: _____ Date of Assessment: _____

Date of Birth: _____ Age: _____ Gender: _____

Relationship Status: _____ Ethnicity: _____

Are there cultural or heritage influences that are important to you of which your counselor should be aware? Yes or No

If yes, please explain: _____

Are there religious or spiritual beliefs that are important to you of which your counselor should be aware? Yes or No

If yes, please explain: _____

Section B: Presenting Problem

1. Briefly describe the problem or concern you most wish help with currently.

2. How would you rate the intensity of the problem or concern that led you to seek professional services? (please circle a number)

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

3. Approximately how long have you had the current problem or concern? _____

4. In what ways have you attempted to cope with this problem or concern?

Section C: Family Background

1. Please list the members of your family.

- a. Father Age: Occupation: Education:
- b. Mother Age: Occupation: Education:
- c. Sibling Age: Occupation: Gender:
- d. Sibling Age: Occupation: Gender:
- e. Sibling Age: Occupation: Gender:
- f. Sibling Age: Occupation: Gender:

2. Is your father deceased? Y or N Year?_____ Mother deceased? Y or N Year?_____

3. What is/was your parents' marital status? _____

4. Please list your step-family members. (please circle "step" or "half")

- a. Step-father Age: Occupation: Education:
- b. Step-mother Age: Occupation: Education:
- c. Step/half sib Age: Occupation: Education:
- d. Step/half sib Age: Occupation: Education:
- e. Step/half sib Age: Occupation: Education:
- f. Step/half sib Age: Occupation: Education:

5. What is your spouse's/partner's Name: _____ Age: _____
Occupation: _____ Education: _____
Deceased: Y or N Year: _____

6. Please list any children of yours.

- a. Child one Age: _____ Adopted: Y or N Gender: M or F
- b. Child two Age: _____ Adopted: Y or N Gender: M or F
- c. Child three Age: _____ Adopted: Y or N Gender: M or F
- d. Child four Age: _____ Adopted: Y or N Gender: M or F
- e. Child five Age: _____ Adopted: Y or N Gender: M or F

7. Please list any step-children of yours.

- a. Step-child one Age: _____ Gender: M or F
- b. Step-child two Age: _____ Gender: M or F
- c. Step-child three Age: _____ Gender: M or F
- d. Step-child four Age: _____ Gender: M or F

8. Please circle any past, present, or impending problems/issues in your family.

- a. physical/sexual abuse b. deaths c. financial / unemployment
- d. frequent relocations e. divorce f. legal problems
- g. injuries / disabilities

Please specify family member(s), which problem/issue, and approximate year of occurrence:

9. Have you personally experienced significant abuse?

None Unsure Emotional Physical Sexual

10. In general, how happy or adjusted were you growing up?

Poor Unsatisfactory Average Substantial Completely

11. How much is your immediate family a source of emotional support for you?

None Little Somewhat Substantial Always

12. How much conflict in values do you currently experience with your parents?

None Little Sometimes Substantial Always

13. Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

Section E: Education and Work Information

1. What is your highest education level? _____

2. What was your major/minor/area of concentration? _____

3. Did you experience any learning problems in school?

None Little Some Substantial Always

Please explain: _____

4. How satisfied are you with your academic progress so far? (please circle a number)

Very satisfied Satisfied Very dissatisfied

5 4 3 2 1

5. What barriers, if any, are impeding your academic progress? _____

6. What is your current job and/or occupation? _____

7. Where are you employed? _____

8. How satisfied are you with your current job and/or occupation? (please circle a number)

Very satisfied		Satisfied		Very dissatisfied
5	4	3	2	1

Section F: Health and Social Issues

1. How is your physical health at present?

Poor Fair Satisfactory Good Excellent

2. Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, diabetes, etc.)

3. Please list any prescribed medications you are presently taking, including dosage and frequency

4. Are you having any problems with your sleep habits? Yes or No

If yes, circle where applicable:

Sleeping too little Sleeping too much Poor quality of sleep

Disturbing dreams Other: _____

5. How many times per week do you exercise? _____ For how long? _____

6. Are you having any difficulty with appetite or eating habits? Yes or No

If yes, circle where applicable:

Eating less Eating more Binge eating Restricting calories

7. Have you had a significant weight change in past two months? Yes or No

8. Do you regularly use alcohol? Yes or No

In a typical month, how often do you have four or more drinks in a 24 hour period? _____

9. Have you ever tried to cut down on the amount of alcohol you consume? Yes or No

10. Has anyone close to you ever been annoyed by your drinking? Yes or No

11. Do you consider your alcohol consumption to be a problem? Yes or No

12. How often do you engage in recreational drug use? _____

13. Do you consider this drug use to be a problem? Yes or No

14. Have you ever experienced legal problems? Yes or No

Nature of problem: _____

15. In the past, how would you rate the quality of your peer relationships?

Very Poor Unsatisfactory Average Good Excellent

16. Approximately how many significant intimate relationships, lasting six months or more, have you had? _____ Are you currently in one? Yes or No

17. Do you have any problems or worries about sexual functioning? Yes or No

If yes, circle where applicable: Performance Problem Sexual Impulsiveness

Lack of Desire Difficulty Maintaining Arousal Worry about STD(s)

Other: _____

18. What is your sexual orientation? Heterosexual Gay/Lesbian Bisexual Unsure

19. Besides family members, approximately how many people can you really count on currently for friendship or emotional support? _____

20. How do you spend your leisure time? _____

Section G: Mental Health History

1. Are you currently receiving psychiatric services, professional counseling or therapy elsewhere?
Yes or No If yes, by whom? _____

2. Have you ever had previous counseling or psychotherapy? Yes or No

If yes, please specify the following: Reason for counseling: _____

Counseling location: _____

Counseling dates: _____

Counseling duration: _____

3. Have you ever been hospitalized for psychiatric reasons? Yes or No

If yes, please specify the following: Reason for hospitalization: _____

Hospital location: _____

Dates of hospitalization: _____

Duration of hospitalization: _____

4. Have you ever been prescribed medication for psychiatric reasons? Yes or No

If yes, please specify the following: Name/dose of medication: _____

Date of prescription: _____

Duration of medication: _____

Prescribing doctor: _____

5. Have you had suicidal thoughts recently? Yes or No

If yes, how often? _____

Have you had them in the past? Yes or No

If yes, how often? _____

6. Have you ever intentionally inflicted harm upon yourself? Yes or No

If yes, how often? _____ Nature of harm: _____

7. Have you ever intentionally hurt someone else? Yes or No

If yes, when? _____ Nature of experience: _____

8. Have you ever experienced any form of traumatic experience? Yes or No

If yes, when? _____ Nature of experience: _____

9. Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

Frequently A Few Times Once Never Unsure

10. How does the future look to you? Poor Fair Neutral Good Excellent

11. Please, describe your future plans. _____

12. What do you hope to accomplish through counseling? _____

13. Is there anything else you would like your counselor to know about you? _____

Thank you for your valuable time and effort!