

CLIENT ASSESSMENT FORM

Client Name: _____ Date: _____

This information is gathered in order to serve as a beginning and as a foundation for our work together. Knowing what issues and concerns you bring to counseling, your history with counseling, and what you hope to accomplish is our starting place and informs the work we do together. Please be assured that ALL your information is maintained in a private and confidential manner in compliance with ALL HIPAA Standards.

1. What are the most troubling stressors in your life & when did they begin?

2. Please list any significant **losses** (death, divorce, job loss, moves, etc.) you have experienced in your life & the approximate dates:

Nature of Loss: _____ Date: _____
Nature of Loss: _____ Date: _____
Nature of Loss: _____ Date: _____

3. Please list any **traumas** (abuse, assault, violence, motor vehicle accidents, etc.) you have experienced in your life & the approximate dates:

Nature of Trauma: _____ Date: _____
Nature of Trauma: _____ Date: _____
Nature of Trauma: _____ Date: _____

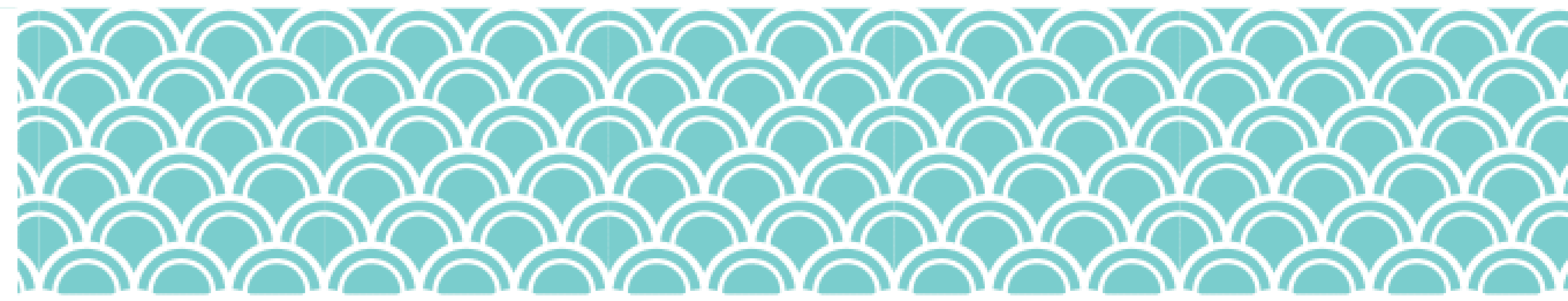
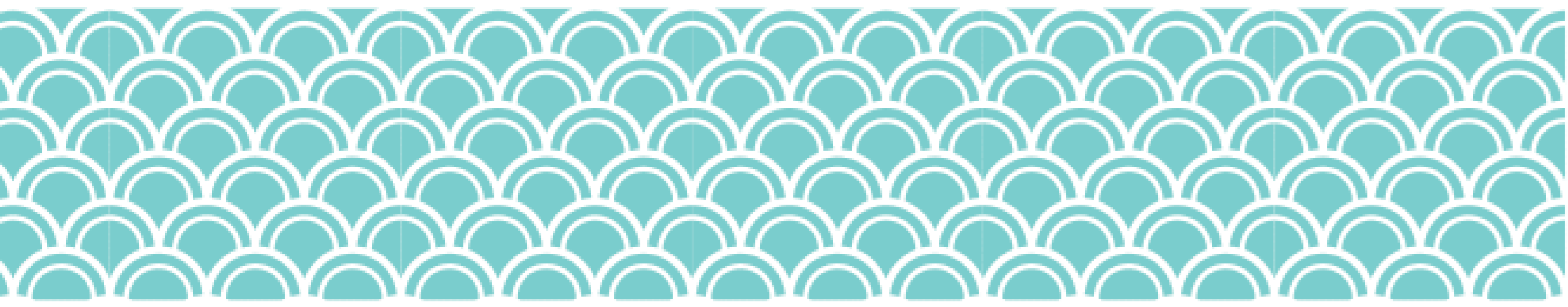
4. Please list any **negative beliefs** about YOURSELF that you have.

(For example, "I am inadequate." "I should have done something." "I am powerless/helpless/trapped.")

Negative Belief: _____
Negative Belief: _____
Negative Belief: _____

5. Do you have children? Yes* (If Yes, please provide the following information) No

First Name: _____ Gender: ___ Age: _____ Place of Residence: _____
First Name: _____ Gender: ___ Age: _____ Place of Residence: _____
First Name: _____ Gender: ___ Age: _____ Place of Residence: _____



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6. Are you currently employed?

- Yes, Full-Time
- Yes, Part-Time
- No, I am not employed and am actively looking for employment.
- No, I am not employed and am *not* seeking employment.

If you are currently employed, do you like your present job situation? Yes No

Comments: _____

5. Check the level of support you feel that you receive from others:

- | | | | | |
|---------------------|-------------------------------|-------------------------------|-------------------------------|---|
| Family | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |
| Friends/Neighbors | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |
| Co-Workers/Employer | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |
| Faith Community | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |

Comments: _____

6. Overall, how do you believe that you are coping with the circumstances in your life? (Circle One)

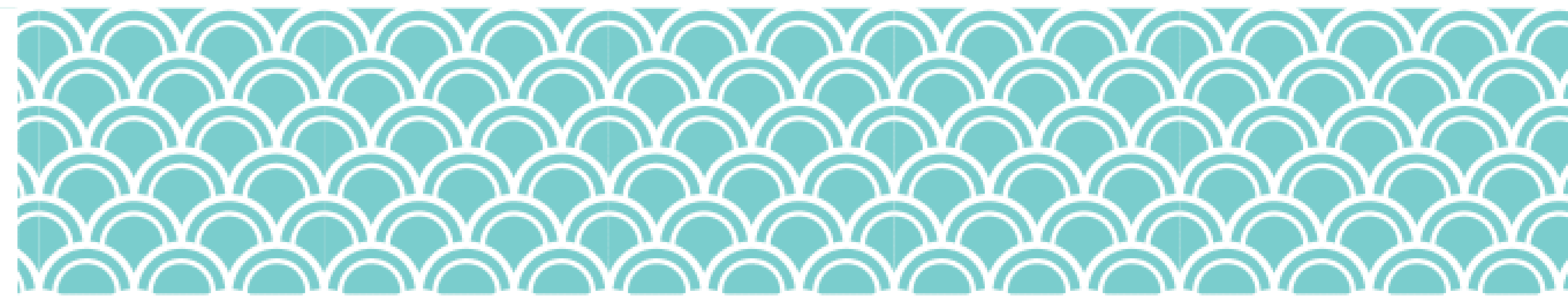
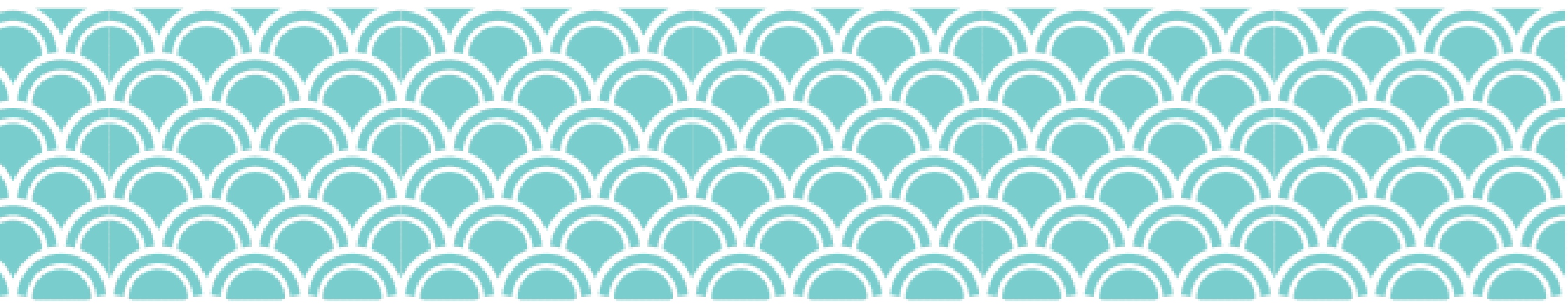
Not Well 1 2 3 4 5 6 7 8 9 10 Really Well

Comments: _____

7. Which of the following are you experiencing at this time? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> Financial Concerns |
| <input type="checkbox"/> Reduced Energy/Fatigue | <input type="checkbox"/> Legal Concerns |
| <input type="checkbox"/> Reduced Concentration/Memory Issues | <input type="checkbox"/> Health Concerns |
| <input type="checkbox"/> Anxiety, Nervousness, Worry, Panic | <input type="checkbox"/> Social Concerns |
| <input type="checkbox"/> Withdrawal from Others/Isolation | <input type="checkbox"/> Relationship Concerns |
| <input type="checkbox"/> Difficulty Expressing My Feelings | <input type="checkbox"/> Academic Concerns |
| <input type="checkbox"/> Family Conflicts | <input type="checkbox"/> Career Concerns |
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Anger/Frustration |
| <input type="checkbox"/> Overwhelmed/Helpless | <input type="checkbox"/> Fearfulness |
| <input type="checkbox"/> Resentment | <input type="checkbox"/> Emptiness |
| <input type="checkbox"/> Guilt | |
| <input type="checkbox"/> Other (Please Indicate) _____ | |
| <input type="checkbox"/> Other (Please Indicate) _____ | |

Comments: _____



Client Name: _____ Date: _____

8. Please list all **medications** you are currently taking, reason, length of time, and prescriber:

Medication _____	Reason _____	Length of Time _____	Prescriber _____
Medication _____	Reason _____	Length of Time _____	Prescriber _____
Medication _____	Reason _____	Length of Time _____	Prescriber _____

Comments: _____

9. Have you ever talked with a Counselor, Psychologist, Psychiatrist before? Yes No

If yes, please list Name(s), Reason(s) for seeking counseling, and approximate Date(s):

Name _____	Reason _____	Date(s) _____	Beneficial? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	Reason _____	Date(s) _____	Beneficial? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	Reason _____	Date(s) _____	Beneficial? <input type="checkbox"/> Yes <input type="checkbox"/> No

Comments: _____

10. Have you ever been **hospitalized** for psychiatric reasons? Yes No

If yes, please list Name of Facility, Reason(s) for hospitalization, and approximate date(s):

Facility _____	Reason _____	Date(s) _____	Beneficial? <input type="checkbox"/> Yes <input type="checkbox"/> No
Facility _____	Reason _____	Date(s) _____	Beneficial? <input type="checkbox"/> Yes <input type="checkbox"/> No
Facility _____	Reason _____	Date(s) _____	Beneficial? <input type="checkbox"/> Yes <input type="checkbox"/> No

Comments: _____

11. What do you hope to **accomplish** through counseling? What are your **GOALS** for counseling?

12. What do you believe are your biggest **strengths**?

13. Is there **anything else** that you believe would be helpful for me to know at this time?

I confirm that the information I have provided is true and accurate: _____

Client Signature

Thank you for taking time to complete this Assessment Form.

We will utilize it to inform our work together.

Please let me know of any changes that should be made to this form as we work together in this counseling relationship.