DONNA HAMPTON
counseling.

MS | LCMHCS | NCC | EMDR-Certified Therapist

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 ❑No, I am not employed and am actively looking for employment.
❑Yes, Part-Time ❑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	❑ Good	❑ Fair	❑Poor	❑Not Applicable
Friends/Neighbors	❑ Good	❑ Fair	❑Poor	❑Not Applicable
Co-Workers/Employer	❑ Good	❑ Fair	❑Poor	❑Not Applicable
Faith Community	❑ Good	❑ Fair	❑Poor	❑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)

❑ Sleep Difficulties
❑ Reduced Energy/Fatigue
❑ Reduced Concentration/Memory Issues
❑ Anxiety, Nervousness, Worry, Panic
❑ Withdrawal from Others/Isolation
❑ Difficulty Expressing My Feelings
❑ Family Conflicts
❑ Depression/Sadness
❑ Overwhelmed/Helpless
❑ Resentment
❑ Guilt
❑ Financial Concerns
❑ Legal Concerns
❑ Health Concerns
❑ Social Concerns
❑ Relationship Concerns
❑ Academic Concerns
❑ Career Concerns
❑ Anger/Frustration
❑ Fearfulness
❑ Emptiness
❑ Other (Please Indicate) _____
❑ 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? ❑Yes ❑No
Name _____ Reason _____ Date(s) _____ Beneficial? ❑Yes ❑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? ❑Yes ❑No
Facility _____ Reason _____ Date(s) _____ Beneficial? ❑Yes ❑No
Facility _____ Reason _____ Date(s) _____ Beneficial? ❑Yes ❑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.

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