

First Health Associates, SC
Counseling Assessment

Date _____

Name _____

Birth date _____

Phone(s): Home _____ Cell _____

E-mail _____

Referral Source

____ Self Referred

____ Friend

____ Relative

____ Physician _____ (Name)

Relationship Status

____ Single

____ Committed Relationship

____ Married/Partnered

____ Separated

____ Divorced

____ Widowed

____ Other _____

Living Situation

____ Alone

____ Roommate(s)

____ Partner/Spouse

____ Parent(s)

____ Children

____ Other _____

Employment Status

____ Not Employed

____ Employed

Type of work _____

Is this a crisis? YES NO

Explanation: _____

Have you used our services before? If Yes, when, whom did you see, what was the major issue?

Have you had previous counseling or other mental health services?

Have you ever seriously considered or attempted suicide? If Yes, Explain.

Do you have any significant medical conditions or significant medical history? If Yes, Explain.

Do you have any significant legal history or current legal issues pending? If Yes, Explain.

Are you currently taking any medications? If Yes, what and for how long?

Please describe your use of alcohol, cigarettes, and recreational drugs.

Describe any events or situations in your childhood that may be affecting your current functioning or situation.

How would you describe yourself?

What would you like to accomplish with this service? (Counseling/Largest Loser)

What about your behavior and feelings would you like to change?

Self- Report Checklist

Please rate an issues below that are concerning you by circling the appropriate number (0, 1, 2, 3).

	No Problem	Mild	Moderate	Severe
Schoolwork and grades	0	1	2	3
Procrastination, motivation and time management	0	1	2	3
Relationship with Co-workers	0	1	2	3
Job satisfaction	0	1	2	3
Weight Concerns	0	1	2	3
Finances/money issues	0	1	2	3
Relationships with friends	0	1	2	3
Living situations/roommate	0	1	2	3
Loss/death of significant person	0	1	2	3
Divorce (own, family)	0	1	2	3
Relationship with romantic partner	0	1	2	3
Relationships with family and parents	0	1	2	3
Sexual orientation issues	0	1	2	3
Gender identity issues	0	1	2	3
	0	1	2	3
Sexual decisions/issues	0	1	2	3
Childhood sexual abuse/molestation	0	1	2	3
Childhood physical abuse/emotional abuse/neglect	0	1	2	3
Rape/sexual assault	0	1	2	3
Sexual harassment	0	1	2	3
Discrimination/oppression (e.g. racism, sexism, homophobia)	0	1	2	3
Legal matters	0	1	2	3
Religious/spiritual issues	0	1	2	3
Shyness, being assertive	0	1	2	3
Self-esteem, self confidence	0	1	2	3
Loneliness,	0	1	2	3
Anxiety, fears, worries	0	1	2	3
Irritable, angry, hostile feelings	0	1	2	3
Suicidal feelings/behavior	0	1	2	3
Dealing with physical disability	0	1	2	3
Chronic health problems	0	1	2	3
Physical stress (headaches, stomach pains, muscle tension)	0	1	2	3
Stress	0	1	2	3
ADHD	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Alcohol and/or other drugs (self, family, partner, friend)	0	1	2	3
Other _____	0	1	2	3

Family/Social Information

Describe any family history of mental health problems including alcohol and drug abuse.

Parents' current relationship status:

Married/Partnered

Separated

Divorced

Widowed

Remarried

Never Married

Other _____

Family Members (parents, step-parents, brothers, sisters, step-siblings, children, significant relatives)

Name/Relationship

Age

How do you get along?

<u>Name/Relationship</u>	<u>Age</u>	<u>How do you get along?</u>
_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____

Client Signature _____ Date _____

Please check a response for each of the 21 items

	None or little of the time	Some of the time	Good part of the time	Most or all the time
I feel downhearted, blue and sad				
Morning is when I feel the best				
I have crying spells or I feel like it				
I have trouble sleeping through the night				
I eat as much as I used to				
I enjoy looking at, talking to, and being with attractive men/women				
I notice that my weight has changed				
I have trouble with constipation				
My heart beats faster than usual				
I get tired for no reason				
My mind is as clear as it used to be				
I find it easy to do the things I used to				
I am restless and can't keep still				
I feel hopeful about the future				
I am more irritable than usual				
I find it easy to make decisions				
I feel that I am useful and needed				
My life is pretty full				
I feel that others would be better off if I were dead				
I still enjoy the things I used to do				
I am currently thinking of suicide				