ASSESSMENT

Name _____ Age ____ Date of Birth _____
Address _____
Phone (home)_____ (work)_____
(cell)_____ Email address _____

Occupation (Specify if you are a student)_____
_____

Please list members of your current household and their relationship to you (include names and ages of children):
_____
_____
_____

For what reasons are you seeking counseling? Include troubling symptoms, recent life transitions, current stressors, etc.

_____
_____
_____
_____
_____
_____
_____

Have you ever sought counseling before? Yes___ No___ (When, with whom)_____

Any history of psychiatric illness? Yes___ No___

Is there a history of psychiatric illness (including addiction) in your family? Yes__No__
If "yes" please specify family member's relationship to you and the nature of the illness: _____

List any medical conditions that you may have along with the name of your physician:_____

Please list any medications you are taking:_____

_____

How often and in what amounts do you use alcohol and/or drugs?

_____

Has anyone ever expressed concern about your drinking habits?

_____

Have you recently had thoughts of death or suicide? Yes___ No___

Have you had problems sleeping lately? Yes___ No___

Have you recently lost or gained a significant amount of weight? Yes ___ No___

Have you noticed changes in your appetite? Yes___ No___

Have there been significant changes in your energy levels? Yes___ No___

Do you have a history of sexual, physical, or verbal abuse? Yes___ No___
(circle all forms of abuse that apply)

_____
_____
_____

Do you have an adequate support system (friends, family, church, sponsor, etc.)?
Yes___ No___ Please describe: _____

What goals do you hope that counseling will help you to achieve?
Be as general or as specific as you wish. Include any other pertinent information or additional comments.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Eating habits and rituals

Body Image

Weight: minimum and maximum weights, desired weight

Menstrual pattern

Use of laxatives, diuretics, or diet pills

Exercise patterns

Bingeing and purging behaviors

Cutting/Self-Injury

Substance abuse, personality, mood and anxiety disorders, suicidal thinking

Medical history

Family history of medical and psychiatric disorders

Abuse issues: physical, sexual, verbal, emotional

Prior treatment

Physical examination:

Blood count, electrolytes, calcium, magnesium, cholesterol, lipids, liver function tests, etc; urinalysis
EKG
Vital signs
Dental exam

Need for hospitalization:

Weight loss of 25% or more
How rapidly was weight lost
Weight prior to weight loss
Physical health as determined by physician
Presence of starvation symptoms
Suicidal ideation
Substance abuse