

CLIENT ASSESSMENT

NAME: _____ DOB: _____ Assessment Date: _____

ADDRESS: _____

PHONES: HM _____ WORK _____ CELL _____

If a Minor, Parents' or Legal Representative's Names

Mother: _____ Father: _____

Sex: ___M ___F Marital Status: ___Single; ___Married; ___Separated/Divorced; ___Significant Other

Spouse's Name: _____ Phone: _____

***EMERGENCY CONTACT** _____ Phone: _____

Relationship to Client _____

	Client's children if adult/siblings if a child	Sex	Date of Birth	Living at Home?	
1.	_____	_____	_____	Y	N
2.	_____	_____	_____	Y	N
3.	_____	_____	_____	Y	N
4.	_____	_____	_____	Y	N
5.	_____	_____	_____	Y	N

*Where do you work? Occupation _____

*Allergies? _____

*Medical Problems? _____

*Current Meds w/ doses/frequency & OTC _____

*Have you had any psychiatric hospitalizations? No ___ If Yes, Hosp name, dates of admit/disch _____

*Have you had previous outpatient therapy? No ___ If Yes, Date(s), W/ Whom? _____

Spiritual History:

In what denomination were you raised? _____

What church do you currently attend? _____

In what ministries are you involved? _____

Have you ever been involved, willingly or unwillingly, in witchcraft? ___ Wicca? ___ SRA? ___ Other cults? ___

Academic History (Adults complete this too)

Highest grade achieved? ___High School ___GED ___Some College ___2-Yr College ___4-Yr College ___Masters ___Doctoral

If student, current grade? _____ Name of school? _____

Did you have any learning problems? _____

Were you placed in special education? _____

Which grade(s) did you repeat? _____

Any problems with separation from parents? _____

Behavior problems? _____

Decline in grades? _____

School refusal/absenteeism? _____

***Legal History (Please include dates of DUI, DWI, arrests, violence, incarcerations & where etc.)** _____

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Please check all that apply to your PAST and check NOW if it is something you have experienced in THE LAST MONTH:

PAST	NOW		PAST	NOW		PAST	NOW	
		Anger			Nightmares			Anxiety
		Cursing			Sleepless nights			Bed-wetting
		Destroying property			Sleep too much			Wetting or soiling self (day)
		Eating too much/binging			Have no energy			Fears
		Verbally abusive			Guilt			Panic
		Hurting yourself			Crying			Phobia
		Seeking sexual activity			Shame			Clumsiness
		Lying			Problem concentrating			Poor Sexual Performance
		Fighting			Weight gain			Decreased sexual desire
		Spending too much			Increased appetite			Difficulty sitting still
		Stealing something			Decreased or/ no appetite			Difficulty paying attention
		Tantruming			Weight loss			Difficulty organizing tasks
		Throwing things			Isolating from others			Forgetful of daily activities
		Using drugs not prescribed			Lacked motivation			Fail to follow directions
		Using illicit drugs			Low self-esteem			Feel like a child when upset
		Using alcohol			Racing thoughts			Flashbacks
		Desire to hurt/kill someone			Too much energy			Hypervigilance
		Wanting to kill yourself			Feel like running away			Exaggerated startle
		Watching pornography			Hearing voices			Seeing things not there

Relationships and Relationship Skills: Please rate G=Good, F=Fair, P=Poor or NA=not applicable.

Mother ____; female siblings ____; female friends ____; female teachers ____; female bosses ____; female in authority ____

Father ____; male siblings ____; male friends ____; male teachers ____; male bosses ____; male in authority ____

Listening skills: _____ Ability to express my thoughts and feelings: _____

Substance use history? No ____ If yes, please answer the following: At what age did you start? _____

Date of last use: _____ What influenced you to start? _____

Drugs of choice: _____

Circle treatments for **substance use**: none NA and/or AA detox rehab individual group intensive outpatient

Trauma History? No ____ If yes, check and elaborate on all that apply:

____ emotional (verbal) abuse _____

____ physical abuse _____

____ sexual abuse _____

____ neglect _____

____ parents/self divorced? _____

____ involved in any accidents? _____

____ death of a loved one or pet? _____

____ abortion _____

____ multiple moves _____

____ immigrated (from where, how old were you?) _____

What brings you to Ephesians at this time?

[CLINICIANS: Complete genogram for family history]