

Counseling and Trauma Services LLC

Initial Assessment

Please provide the following information. By knowing about you and your history, I can get a better idea of your current needs and understand you better. All information is voluntary.

How did you find our office or web site? _____

Name _____

Address _____

Email _____

Phone number, including area code

Cell phone (____) ____ - _____

Home phone (____) ____ - _____

Work phone (____) ____ - _____

Please star which phone number you would like us to use first.

Birth date ____/____/____
Month Day Year

Emergency Contact

Name _____

Relationship _____

Phone number including area code (____) ____ - _____

Are you a veteran? _____

Are you single __, married __, or divorced __?

Sexual Orientation: _____

Do you believe in God? Yes ___ No ___ Attend church? Yes ___ No ___

Who do you live with? Please state their names and ages. How do you get along with them?

Do you have any current or past legal issues? No ___ Yes ___

What are/were they? _____

Family Doctor information:

Name: _____

Address: _____

Phone Number: (___) ___ - ____

Presenting Problem, why are you interested in counseling?

Have you had past mental health treatment or counseling? Please write the name of past mental health providers.

Past hospitalizations, both medical and psychiatric:

Current medical problems:

Current medications:

Have you or your family ever suspected or been diagnosed with a mental health disorder? Yes ___ No ___

If so, who was it and what was the suspected disorder?

Do you have difficulties with anxiety? Yes ___ No ___

Have you ever had a panic attack? Yes ___ No ___

If so, how many do you have daily? ___ weekly? ___ monthly? ___

If you have difficulty with anxiety or panic attacks, what helps you to feel better? _____

Have you or anyone in your family ever thought about or tried to hurt or kill yourself or anyone else? Yes ___ No ___

If so, who was it, when did it happen and what was the method?

Have you ever had the experience where you felt physically or mentally threatened and / or afraid? Yes ___ No ___

Exposure to natural or man made disasters? Yes ___ No ___

Physical abuse? Yes ___ No ___

Emotional abuse? Yes ___ No ___

Sexual abuse? Yes ___ No ___

Domestic violence? Yes ___ No ___

Medical treatments? Yes ___ No ___

War? Yes ___ No ___

Any other type of mental health problems? Yes ___ No ___

Do you ever lose time? Yes ___ No ___

Do you ever have difficulty concentrating or focusing? Yes ___ No ___

Did you ever have an experience where you seem to be detached from your body or observing yourself from the outside? Yes ___ No ___

Have you ever experienced feeling disconnected or unfamiliar with your environment? Yes ___ No ___

Do you have nightmares? Yes ___ No ___ If so, what is the frequency?
Monthly ___ Weekly ___ Number of times per week ___

Have you in the past or currently used drugs or alcohol? Yes ___ No ___

If you answered yes, please answer the following.

D&A use	current use	past use	date of last use	family history
Alcohol				
Opiates				
Amphetamines				
Cocaine				
Hallucinogens				
Marijuana				
Heroin				
Inhalants				
Other drugs				

Did you use any other drugs that are not listed here like Suboxone?

Yes ___ No ___

If so, what were they? _____

Have you ever been in a D&A rehabilitation program? Yes ___ No ___

Do other people think that you're drinking or drug use is getting out of control? Yes ___ No ___

Have you every tried to quit and were unsuccessful? Yes ___ No ___

Have you had to spend more time and money on drugs or alcohol?

Yes ___ No ___

Have you had to use or drink more in order to get the same effect?

Yes ___ No ___

Have you used alcohol or drugs in dangerous situations? Yes ___ No ___

Could you be developing a tolerance to drugs or alcohol? Yes ___ No ___

Are drugs or alcohol starting to interfere with your life? Yes ___ No ___

Signature of Client _____

Date: ___ / ___ / _____