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: ____/____/_____