Joyful Hearts Counseling

Client Information/Assessment Form

Client Name: _____ Birth Date: ____ /____ /_____
(Last) (First) (M.I.)

Client Address:_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Best method of contact for appointment reminders? □text □e-mail □phone call □other_____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Place of Employment: Telephone:

_____ _____

In case of an Emergency: Contact Person: Telephone:

_____ _____

Treatment History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

_____

When and how long?

_____

Have you ever been hospitalized for a psychiatric condition? □ No □ Yes
If yes, describe date(s) and circumstances:

_____

_____

Are you currently taking any prescription medication? □ No □ Yes Please list:

_____

_____

If yes, who is your prescriber:_____

Have you ever been prescribed psychiatric medication? □ No □ Yes
Please list and provide dates, along with the prescriber names:

_____

_____

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General Health

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this, and what symptoms do you have?

_____

_____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe?

_____

8. How often do you drink alcoholic beverages?_____ How many drinks at a time_____

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10.Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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Presenting Concerns

Below is a list of concerns commonly reported by people seeking counseling. To facilitate the best assessment of your current situation, please check the number indicating the degree to which each item is *presently a concern for you.*

(1) Not at all (2) A little bit (3) Quite a bit (4) Extremely

1. Dealing with stress or pressure	1 □	2 □	3 □	4□
2. Feeling sad, depressed or down	1 □	2 □	3 □	4□
3. Death or illness of a significant person	1 □	2 □	3 □	4□
4. Difficulties related to sexual orientation/identity	1 □	2 □	3 □	4□
5. Family relationships	1 □	2 □	3 □	4□
6. Abuse in relationship with partner/family member	1 □	2 □	3 □	4□
7. Feeling anxious, worried, or panicky	1 □	2 □	3 □	4□
8. Feeling unmotivated, difficulty concentrating	1 □	2 □	3 □	4□
9. Feeling irritable, tense, angry, or hostile	1 □	2 □	3 □	4□
10. Money or finances	1 □	2 □	3 □	4□
11. Feeling isolated and uncomfortable with others	1 □	2 □	3 □	4□
12. Values, beliefs, or spirituality concerns	1 □	2 □	3 □	4□
13. Sexual abuse in childhood	1 □	2 □	3 □	4□
14. Physical or verbal abuse in childhood	1 □	2 □	3 □	4□
15. Someone else's habits or behaviors	1 □	2 □	3 □	4□
16. My own unwanted habits or behaviors	1 □	2 □	3 □	4□
17. Rape, sexual assault, or sexual harassment	1 □	2 □	3 □	4□
18. Eating concerns (i.e., bingeing, restricting, vomiting, laxative use, etc.)	1 □	2 □	3 □	4□
19. Weight or body image concerns	1 □	2 □	3 □	4□
20. Problems with partner/spouse/family member	1 □	2 □	3 □	4□
21. Sexual concerns (i.e., pregnancy, sexual functioning, sexually transmitted disease, etc.)	1 □	2 □	3 □	4□
22. Physical health problems	1 □	2 □	3 □	4□
23. Urge to harm others	1 □	2 □	3 □	4□
24. Concerns about my own drug or alcohol use	1 □	2 □	3 □	4□
25. Thoughts of harming myself	1 □	2 □	3 □	4□
26. Other (please explain):	1 □	2 □	3 □	4□

_____

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Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

Who do you consider to be a part of your support system?

_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____

Is there any other important information about you that would be helpful to know?

_____
_____
_____