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Self Assessment

Date:_______________

Name:____ Date of Birth:_______________

What is happening in your life which resulted in this appointment? ______________________________
____
____
____

What would you like to see accomplished in therapy? ____
____
____

Have you ever seen a psychiatrist/clinical nurse specialist in the past? □ Yes □ No
If yes, who?____ When?_______________

If yes, where you prescribed medications? □ Yes □ No
What medications? ____

Have you had previous outpatient therapy? □ Yes □ No
If yes, what was accomplished? ____
____

Check any of the following problems that you experience:

□ Anger management	□ Intrusive Thoughts	□ Sadness
□ Problem drug abuse	□ Sexual problems	□ Bladder control problems
□ Appetite disturbance	□ Loneliness	□ Fears/phobias
□ Stomach appearance	□ Nightmares	□ Divorce/ Separation
□ Fatigue	□ Relationship problems	□ Obsessive Thoughts
□ Anxiety	□ Feelings of unreality	□ Low self-esteem
□ Flashbacks	□ Pain	□ Marital/family problems
□ Bowel problems	□ Tingling/numbness	□ Poor concentration
□ Difficulty relaxing	□ Feelings of unreality	□ Issues of loss

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- ☐ Poor impulse control
- ☐ Difficulty trusting
- ☐ Depression
- ☐ Lack of motivation, fatigue
- ☐ Feeling hopeless/ helpless
- ☐ Excessive guilt
- ☐ Suicidal thoughts
- ☐ Homicidal thoughts
- ☐ Losing track of time
- ☐ Anger/frustration
- ☐ Negative thinking
- ☐ Excessive use of drugs and/or alcohol
- ☐ Mood swings
- ☐ Family Conflict
- ☐ Relationship problems
- ☐ Difficulty trusting
- ☐ Defies rules
- ☐ Worthlessness
- ☐ Agitation/ Irritability
- ☐ Isolation/social withdrawal
- ☐ Poor stress management
- ☐ Delusions (false ideas)/Hallucinations
- ☐ Nervousness
- ☐ Trembling/shaking
- ☐ Chills/ hot flashes
- ☐ Difficulty relaxing
- ☐ Panic attacks
- ☐ Obsessive/compulsive behaviors
- ☐ Cannot hold onto an idea, racing thoughts
- ☐ Excessive behaviors (spending/gambling)
- ☐ Financial issues
- ☐ Not thinking clearly/confusion
- ☐ Argues, Confrontational
- ☐ Excessive use of prescription medications
- ☐ Sleep disturbance/ insomnia (too much, too little)
- ☐ Confusion
- ☐ Other problems/symptoms: ____

Current Medications	Dose	Last dose	Taken for