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? ____

How do you feel about God? ____

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.)** ________________

____

____

Please turn over and complete the other side.

CLIENT ASSESSMENT

NAME: ____ **Assessment Date** __________________

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

<u>Relationships and Relationship Skills</u>: 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: ____________

<u>Substance use history</u>? 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

<u>Trauma History</u>? 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?) ____

<u>What brings you to Ephesians at this time?</u>

____

Client's (Representative's) Signature____ **Date** _______________

[**CLINICIANS: Complete genogram for family history**]