



NAME: _____ DOB: _____ Assessment Date: _____

ADDRESS: _____

PHONES: HOME _____ WORK _____ CELL _____

If a Minor, Parents' or Legal Representative's Names

Mother: _____ Father: _____

Sexual Orientation: ___M ___F ___L ___G ___B ___T ___Q

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 faith tradition were you raised? _____

What is your current relationship with God? _____

Name of your current place of worship? _____

Do you want to incorporate Christian Pastoral Counseling in your counseling? _____

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.)**



CLIENT ASSESSMENT for Leslie J. Marler cont.

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:

Table with 8 columns: PAST, NOW, and 6 symptom categories. Symptoms include 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, Feeling restless/ keyed up, 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, Lack of pleasure in most things, Sad or empty most days, Irritable.

Relationships and Relationship Skills: 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: _____

Substance use history? 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

History 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?) _____

What brings you to counseling at this time? _____

Client's (Representative's) Signature _____ Date _____