



CLIENT ASSESSMENT for clients of Dr. Sheila Cuomo

NAME: _____ DOB: _____ Assessment Date: _____

ADDRESS: _____

PHONES: HOME _____ 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.)**



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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 9 columns: PAST, NOW, Symptom, PAST, NOW, Symptom, PAST, NOW, Symptom. Rows include symptoms like Anger, Nightmares, Anxiety, Cursing, Sleepless nights, Bed-wetting, etc.

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 _____