Navigator Counseling & Psychotherapy, Inc.

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New Client Assessment Form

Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: (First, Middle, Last) _____ Cell # _____

Place of Birth: _____ Ethnic/Cultural Background: _____ Religion: _____

Native Language: _____ Relationship Status: _____ Education (highest degree/grade/level): _____

Occupation: _____ Annual Income: _____ Employer: _____

Referred by: _____ **May I thank your referral source?** ❑ Yes ❑ No

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time:

Has anything happened that may have brought on/intensified the problems you are experiencing? ❑ Yes ❑ No Please explain: _____

_____

When (month/year) did you first begin to experience these problems? _____

How many days, weeks, months, or years have you been experiencing these problems? _____

How often do you experience these problems? (Check the one that best describes your current experience).

- ❑ Most of the day, every day
- ❑ Some part of the day, every day
- ❑ Most of the day on most days
- ❑ Some part of the day on most Days
- ❑ More than once a week
- ❑ More than once a month
- ❑ Other _____

How much is/are the problems affecting you? ❑ Mildly ❑ Moderately ❑ Severely

In what areas do your problems impact your life? (Check all that apply)

- ❑ Lifestyle (the way you live your life)
- ❑ Activities (things you normally do or would like to do)
- ❑ Relationships (your ability to form or maintain relationships with others)
- ❑ Eating
- ❑ Sleeping
- ❑ Mood

Have you ever attempted suicide? ❑ Yes ❑ No If yes, when_____

_____

Have you been thinking about suicide recently? ❑ Yes ❑ No If yes, when_____

_____

Have you ever thought about harming or killing someone else? ❑ Yes ❑ No If yes, when? _____

_____

Have you been thinking about harming or killing someone else? ❑ Yes ❑ No If yes, who? _____

_____

_____

Adult Problems Checklist

Please check all that apply to you

- ❑ Feeling depressed
- ❑ Low energy
- ❑ Low self-esteem
- ❑ Poor concentration
- ❑ Lack of interest/joy
- ❑ Feeling hopeless
- ❑ Feeling worthless
- ❑ Feeling guilty/shameful
- ❑ Sleep change ↑ or ↓
- ❑ Loneliness
- ❑ Bad dreams/Nightmares
- ❑ Feeling Ignored
- ❑ Feeling Abandoned
- ❑ Appetite change↑ or ↓
- ❑ Mood swings
- ❑ Isolating
- ❑ Social withdrawal
- ❑ Sadness/Loss
- ❑ Weight problems
- ❑ Stress/Worry
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Heart racing
- ❑ Chest pain or heaviness
- ❑ Chills/hot flashes
- ❑ Tingling/numbness
- ❑ Pain
- ❑ Fear of dying
- ❑ Fear of going "crazy"
- ❑ Nausea
- ❑ Fears/Phobias
- ❑ Obsessions
- ❑ Compulsions
- ❑ Thoughts racing
- ❑ Disorganization
- ❑ Procrastination
- ❑ Can't hold onto an idea
- ❑ Anger/Frustration
- ❑ Suspiciousness
- ❑ Mistrustfulness
- ❑ Perfectionist behavior
- ❑ Lying
- ❑ Trouble making friends
- ❑ Trouble keeping friends
- ❑ Arguing
- ❑ Unusual rituals/habits
- ❑ Impulsiveness
- ❑ Excessive behaviors
- ❑ Unusual beliefs
- ❑ Hallucinations
- ❑ Sexual problems
- ❑ Self injurious behaviors
- ❑ Eating problems
- ❑ Body image Problems
- ❑ Shyness
- ❑ Lack of social support
- ❑ Stealing
- ❑ Unusual behaviors
- ❑ Feeling confused
- ❑ Feeling "not real"
- ❑ Feeling detached
- ❑ Feeling "hyper"
- ❑ Financial problems
- ❑ Grief/bereavement
- ❑ Health problems
- ❑ Losing track of time
- ❑ Problems with memory
- ❑ Unpleasant thoughts
- ❑ Recurring bad thoughts
- ❑ Work/School Problems
- ❑ Career indecision
- ❑ Destruction of property
- ❑ Self-criticism
- ❑ Family problems
- ❑ Relationship problems
- ❑ Parent/child problems
- ❑ Use of alcohol
- ❑ Use of drugs
- ❑ Sexual Compulsion
- ❑ Gambling Compulsion
- ❑ Shopping Compulsion
- ❑ Blackouts
- ❑ Abuse **(Past)**
  - ❑ Physical
  - ❑ Sexual
  - ❑ Domestic Violence
  - ❑ Emotional
  - ❑ Spiritual
  - ❑ Other:_____
- ❑ Abuse **(Current)**
  - ❑ Physical
  - ❑ Sexual
  - ❑ Domestic Violence
  - ❑ Emotional
  - ❑ Spiritual
  - ❑ Other:_____
- ❑ Legal Problems
- ❑ Experienced Trauma
- ❑ Witnessed Trauma
- ❑ Loss of a relationship
- ❑ Death of someone close
- ❑ Other (describe):

Current Life Experiences

I live in a/an: ❑ Apartment ❑ House ❑ Condo/Townhouse ❑ Campus Housing ❑ Mobile Home ❑ Rooming House ❑ Other

I live with:

Name	Age	Relationship to me	Problems?

Other significant persons in my life who do not live with me include:

Name	Age	Relationship to me	Problems	Lives where?

Problems or changes in my family or other important interpersonal relationships:

Date(s)	Persons Involved	Relationship to me	Problems or Changes

Problems or changes in occupational, educational, social, or recreational functioning:

Date(s)	Problems or Changes

My sources of satisfaction: _____

My sources of stress: _____

My leisure activities: _____

My current life goals: _____

What I hope to gain from counseling/therapy: _____

My typical day is as follows (attach extra sheets, if necessary):

_____

_____

_____

_____

History of Counseling or /Therapy

Are you **currently** being treated by a counselor, psychologist, psychiatrist, and/or physician for the problems noted above? ❑ Yes ❑ No
If yes, please provide the following information:

Date(s)	Name of Professional	Address	Treatment Type (counseling, therapy, medication, etc.)

Please provide information regarding **previous** treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional	Address	Treatment Type	Why treatment ended

Have you ever been hospitalized for treatment of an emotional or mental disorder? ❑ Yes ❑ No
If yes, please provide the following information:

Date(s)	Name of Hospital or Facility	Address	Reason for Hospitalization

Medical History

Please complete the information below regarding past and current medical conditions and treatment:

Date(s)	Physician Name / Address	Condition	Treatment	Results

Please list any allergies/sensitivities/drug reactions:

Please list all current prescription and over the counter medication use:

Date	Medication	Dose	Frequency of use	Condition Treated

Please list any previous prescription and over the counter medication use significant to your counseling/therapy:

Date(s)	Medication	Dose	Frequency of use	Condition Treated

Please note any current or previous use of street drugs, tobacco products, or alcohol:

Date(s)	Type Used	Frequency of Use	Amount Typically Used	When ended (if applicable)

Please list any hospitalizations or surgeries:

Date(s)	Hospital/Facility	Physician	Condition	Type Treatment/Surgery

Family of Origin

Please list the members of your family of origin in the order that they were born. Include current ages. Example: Maternal grandmother (deceased), Mother (age 50), father(age 49), sister Anne (age 29), brother Larry (age 27), me (age 24) lived in the childhood home.

Please describe the background or status of your family of origin for the following categories:

Socioeconomic:

Religious:

Ethnicity/Culture:

Briefly describe any of the following that apply to your family of origin:

Crisis or other significant events:

Any emotional, psychological, or physical illness: (Examples: cancer, diabetes, heart disease, depression, alcoholism, drug abuse or addiction, family violence, depression, suicide)

Parenting styles of your mother, father, and other caretakers? Who did what and how?

Communication styles in your family of origin? Who did most of the talking, teaching, and connecting?

Please use 3-5 words to describe your childhood/adolescent relationship with the following family members (e.g. close, conflicted, jealous, angry, abusive, loving, intrusive)

- Mother:
- Father:
- Stepparent:
- Siblings:
- Other significant family members/Friends/Mentors:

Please describe your current relationship with the following family members

- Mother:
- Father:
- Stepparent:
- Siblings:
- Other significant family members/Friends/Mentors:
- Spouse, or significant other:
- In-laws:
- Your Children/Stepchildren/Grandchildren:
- Your employer/coworkers:

Developmental History

Briefly describe your (1) physical, (2) psychological, (3) emotional, (4) intellectual, (5) social, (6) spiritual, and (6) academic development, and (7) any significant experiences affecting you during the following stages of your life (attach extra sheets, if needed):

Prenatal development and infancy (conception up to age 2):

Early Childhood (age 2 through age 5):

Middle and Late childhood (age 6 through age 11):

Adolescence (age 12 through age 17):

Adulthood (age 18 and up):

If there is anything additional that you would like to share which you believe would be helpful for your therapist to know, please describe:

_____

_____

_____

_____

Client/Patient Signature: _____ Date: _____

Thank you for taking the time to complete this assessment questionnaire. It will insure that essential information is shared with your therapist.