Reclaimed Counseling Center

Name: **Date:**

Initial Assessment

Briefly describe your present problem:

Have you been diagnosed with any mental health issues in the past? If yes, please explain:

Have you been in counseling previously? If yes, what did you find helpful? What didn't work for you?

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO

If yes, please explain:_____

What was the last year of school you completed? _____

Family and Significant Relationships

MOTHER	____ living	FATHER	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents?

If so, whom?

Where do your parents live? Mother: Father

Describe your relationship with your mother while growing up and currently

Describe your relationship with your father while growing up and currently

Overall describe your experience growing up:

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/ someone

If currently married, when were you married? _____

If living w/someone, how long? _____Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Suicide Risk

Are you currently thinking about suicide? _____

Previous Attempts Dates _____

Injury Suffered Due to Attempt_____

At time of attempt ___sober ___intoxicated, under influence of _____

Past Ideation ___Plan ___Intent ___Access to Means

Family History of Suicide

Self Injury

Have you in the past or do you currently self injure?

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____ **Legal Screening**

Incarceration, Arrest, Pending Court

_____

_____

Abuse Screening

Have you experienced physical, sexual, or emotional abuse?

Drugs and Alcohol

Do you use recreational drugs? YES NO If no, have you used previously? YES NO

If yes, when did you stop? _____

Type of Drug How much How often

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

Type of Alcohol How much How often

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind?

Current Medications/Allergies

Current medications being taken:

1)_____ Dosage/Freq_____ Purpose_____

2)_____ Dosage/Freq_____ Purpose_____

3)_____ Dosage/Freq_____ Purpose_____

4)_____ Dosage/Freq_____ Purpose_____

5)_____ Dosage/Freq_____ Purpose_____

Prescribed by:

Medical History

Describe any important medical history, chronic ailments, or other health problems you experience:

Name Of Primary Care Physician

Address:_____

Phone: _____

Health problems or important medical history about your immediate family members and close relatives, including chronic ailmen

_____

Family History of Mental Illness: