Initial Assessment

Janna Flower, MA LPC

Name: ______________________________ Date: ____________________

What has happened:

(Please briefly describe significant events, previous treatment or other relevant information from your past)

What is happening:

(Please briefly report current situations, concerns or changes)

Any other information I should know?

What are your goals for therapy?

How will you know when therapy is complete?

This is a strictly confidential document, and will not be shared without your consent.

Please check all that apply.

- ◻ Anxiety or nervousness
- ◻ Attention problems, lack of concentration
- ◻ Changes in situation: new job, loss of job, move, divorce, marriage, other: ___________
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- ◻ Childhood or past issues (your own)
- ◻ Conflict
- ◻ Confusion
- ◻ Compulsions
- ◻ Decision making
- ◻ Delusions (false beliefs)
- ◻ Dependence
- ◻ Depression, low mood, sadness, or inability to feel pleasure
- ◻ Divorce, separation
- ◻ Drug use--prescription meds, OTC meds, street drugs, alcohol, cigarettes, other:
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- ◻ Eating (over-eating, under-eating, change in appetite or weight)
- ◻ Emptiness, hopelessness or guilty feelings
- ◻ Failure, or fear of failure
- ◻ Fatigue
- ◻ Fears, phobias:___________________________
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- ◻ Financial trouble
- ◻ Friendship troubles
- ◻ Gambling
- ◻ Grief, loss, death
- ◻ Guilt
- ◻ Health or medical problems: _______________
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- ◻ History of abuse: physical, sexual, emotional, or neglect, or present abuse.
- ◻ Housework, chores, schedules
- ◻ Impulsiveness, loss of control, outbursts
- ◻ Inferiority feelings
- ◻ Judgment problems, risk taking
- ◻ Legal troubles
- ◻ Loneliness
- ◻ Marriage/couple issues (conflict, distance, affairs, disappointment, etc)
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- ◻ Memory
- ◻ Mood swings
- ◻ Motivation
- ◻ Nervousness, tension
- ◻ Obsessions, compulsions (distressing thoughts or actions that repeat themselves)
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____
- ◻ Pain/Headaches or other: ________________
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- ◻ Panic or anxiety attacks
- ◻ Parenting
- ◻ Perfectionism
- ◻ Procrastination
- ◻ Relationship problems
- ◻ Self-esteem
- ◻ Self-harm behaviors; cutting
- ◻ Self-neglect, poor self care
- ◻ Sexual issues, pornography
- ◻ Shyness
- ◻ Sleep difficulties (too much, too little, nightmares)
- ◻ Spiritual concerns: ___________________
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____
- ◻ Stress
- ◻ Suspicions
- ◻ Suicidal thoughts or vague thoughts of death/not existing
- ◻ Temper, anger
- ◻ Threats, violence, aggression
- ◻ Work or career concerns: ______________
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