Name: _______________
Date of completion: _______________

Self Assessment Form

What is happening in your life which resulted in this appointment? What would you like to see accomplished in therapy?
____
____

CHIEF COMPLAINTS (Check all that apply and please add a brief description if possible)

- Depression: ____
- Low energy/fatigue: ____
- Low self-esteem: ____
- Poor concentration:____
- Hopelessness: ____
- Addiction issues: ____
- Obsessions/compulsive behaviors: ____
- Thoughts racing/can't hold onto an idea: ____
- Eating Problems (over/under/obesity): ____
- School/work problems: ____
- Excessive or impulsive behaviors: ____
- Delusions/hallucinations: ____
- Not thinking clearly/confusion: ____
- Difficulty trusting others: ____
- Feeling that you/things around you are not real: ____
- Lose track of time:____
- Unpleasant thoughts won't go away: ____
- Anger/frustration management problems: ____
- Easily agitated/annoyed: ____
- Defies rules/blames others: ____
- ADHD symptoms: ____
- Argues: ____
- Excessive use of drugs and/or alcohol: ____
- Excessive use of prescription medications: ____
- Blackouts: ____
- Flashbacks (not drug related): ____
- Domestic violence issues: ____
- Relationship, marital or family problems: ____
- Sexual or physical abuse or neglect issues : ____
- Other trauma history (accident, fire, etc.): ____
- Suicidal thoughts/actions (circle): ____
- Self-harm thoughts/actions (circle): ____
- Worthlessness: ____
- Guilt____
- Sleep disturbance (more/less): ____
- Appetite disturbance (more/less): ____
- Aggressive behaviors: ____
- Thoughts of hurting someone: ____
- Isolation/social withdrawal: ____
- Sadness/loss: ____

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- Loneliness: ____
- Stress/anxiety/panic attacks: ____
- Heart pounding/racing: ____
- Chest pain: ____
- Trembling/shaking: ____
- Sweating/chills/hot flashes: ____
- Tingling/numbness:____
- Fear of dying: ____
- Fear of going crazy: ____
- Nausea/stomach problems: ____
- Phobias: ____
- Headaches: ____
- Nightmares: ____
- Other problems/symptoms: ____

What types of previous therapy have you tried? With Whom? When? What was helpful and what wasn't helpful?
____
____

Who is your current prescribing psychiatrist? ___________________________How long have you been under this psychiatrist's care? _____________________. Please add any additional psychiatrist names? __________________
____

Current Psychiatric Medications, list:____

Helpful? Yes __ No __ Some ___

Historical Psychiatric Medications, list: ____

Helpful? Yes __ No __ Some ___

List all forms of Psychiatric Hospitalization stays: (partial or full hospitalizations, include Baker Act and/or Voluntary admissions to Crisis Stabilization Units); please include dates and locations:
____
____

Please list all medical conditions both current and historical: (Include Medications currently prescribed):____
____
____

Please list the name/address of your primary care physician and most recent visit/check-up:
____

Please add any other additionally relevant information:

____

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