Client Information/Initial Assessment

CORE LIFE COUNSELING
...Where The Journey Begins

Name: _____ Today's Date: _____

Address: _____ DOB: _____

City, State, Zip: _____ Age: _____

Primary Phone: _____ OK to leave message: Y or N

Cell Phone: _____ OK to leave message: Y or N

Email: _____ Ok to send emails: Y or N

Problem Assessment: ***Please check all that apply:***

☐ Marital issues ☐ Health issues ☐ Job issues

☐ Financial issues ☐ Parent/child issues ☐ Childhood issues

☐ Trauma issues ☐ Relationship Issues ☐ Communication issues

Symptoms: ***Please check all that apply:***

☐ Change in sleep pattern ☐ Depressed mood ☐ Mood swings

☐ Decreased interest or pleasure ☐ Decrease energy ☐ Anger problems

☐ Decreased concentration ☐ Change in appetite ☐ Thoughts of death

☐ Decreased motivation ☐ Increased anxiety/worry/panic

☐ Other _____

What recent event prompted you to seek counseling? _____

_____

_____

Counseling/Treatment History:

Date	Provider	Problem/Issue	Duration

Client Information/Initial Assessment

Have you ever received a psychiatric diagnosis? Y or N If Yes, please explain:

_____

List any medications you are currently taking for depression, anxiety, and/or sleep: ___

_____

Name of current doctor and/or therapist: _____

List any Health Problems:

Problem	Date	Treatment

Substance use history: *Current and past usage:*

Substance	Amount	Frequency	Age of 1st use	Last use

Do you, family or friends see your current usage as a problem? Y or N

If Yes, Explain: _____

Describe any family history of substance abuse: _____

_____

Nutrition:

Do you feel you have a balance, healthy eating pattern? Y or N

If No, Explain: _____

Legal History: Please check all that apply:

☐ Charges pending ☐ Incarcerations ☐ Parole

☐ Convictions ☐ Probation ☐ Charges as a minor

☐ Bankruptcy ☐ Civil suits ☐ Child custody problems

Client Information/Initial Assessment

☐ Child Protective Services involvement

Family of Origin:

Name	Relation	Age	Living Y or N	Substance Abuse Y or N

What was your birth order? _____

Who primarily raised you? _____

Describe your Childhood: _____

_____

Do you have any traumatic experiences as a child? Explain: _____

Have you ever been the recipient of unwanted sex acts? Y or N If Yes, Explain:

_____

Have you ever been a victim of abuse, neglect, violence or rape? Y or N

If Yes, Explain: _____

_____

Information about Abuse suffered or witnessed:

Type	Y/N	When, Who and other information
Emotional-includes yelling, screaming, cursing		
Physical-includes hitting, pushing, withholding food,		

water, sleep		
Sexual-includes words, looks, touching		

Have you ever had an abortion or a child of your been aborted? Y or N

Significant Life Events: ***Please check all that apply:***

☐ Death of parent ☐ Divorce of parents ☐ Death of sibling

☐ Death of other family member ☐ Death of a child ☐ Chronic illnesses

☐ Loss of friendship ☐ Abandonment ☐ Multiple moves

Marital History:

Name of spouse: _____ Date married: _____

Previous marriage (s)?

Name	Year Married	Year Divorced

List names and ages of children:

Name	Age	How do you get along?

Religious Background:

Describe your spiritual beliefs: _____

_____

Client Information/Initial Assessment

Do you actively attend church? Y or N

Education history:

Highest grade level achieved: _____

What extra-curricular activities did you participate in? _____

_____

What was school like for you? _____

_____

Employment Information:

Employer Name: _____

Currently employed? Y or N Hours per week? _____ Position: _____

Have you ever been fired or laid-off? Y or N If Yes, Explain: _____

_____

Describe your relationship with co-workers: _____

_____

Describe your relationship with authority figures: _____

_____

Additional Information:

Is there anything else you want the counselor to know about you? _____

_____

What would you like to accomplish through counseling? _____

_____

_____

How were you referred? _____

_____ _____

Client Signature Date