Comprehensive Counseling Center
Self Assessment

Your name____

What is happening in your life which resulted in this appointment?

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What would you like to see accomplished in therapy?

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CHIEF COMPLAINTS (CHECK ALL THAT APPLY TO YOU)

___Depression
___Low Energy
___Low self-esteem
___Poor concentration
___Hopelessness
___Worthlessness
___Guilt
___Sleep disturbance (more/less)
___Appetite disturbance (more/less)
___Thoughts of hurting myself
___Isolation/social withdrawal
___Sadness/loss
___Stress
___Anxiety/panic
___Heart pounding/racing
___Chest pain
___Trembling/shaking
___Sweating
___Chills/flashes
___Tingling/numbness
___Fear of dying
___Fear of going crazy
___Nausea
___Phobias
___Obsessions/compulsive behavior
___Thoughts racing
___Can't hold onto an idea
___Excessive behavior (spending, gambling)
___Delusions/hallucinations
___Not thinking clearly/confusion
___Feeling that you are not real
___Feeling that things around you are not real
___Lose track of time
___Unpleasant thoughts won't go away
___Anger/frustration
___Easily agitated/annoyed
___Defies rules
___Blames others
___Argues
___Excessive use of drugs
___Excessive use of alcohol
___Excessive use of prescription medications
___Blackouts
___Physical abuse issues
___Sexual abuse issues
___Spousal abuse issues
___Other problems/symptoms

____

Previous outpatient therapy? ___No ___ Yes, with ___________________________________

When?__________________ What was accomplished?

Previous hospitalization for mental health treatment ___No ___Yes?

When?______________ Where? ________________Treatment_______________________________

Medications:
Drug name Dosage Prescribed by?

____________________/______________________________/_____________________________________

____________________/______________________________/____________________________________

____________________/______________________________ /_____________________________________