SELF-ASSESSMENT

Low to High 1 to 10 in intensity as applies *

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

_____

What would you like to see accomplished in therapy? _____

_____

CHIEF COMPLAINT (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 yourself
__ Thoughts of hurting someone
__ Isolation/social withdrawal
__ Sadness/loss
__ Stress
__ Anxiety/panic
__ Heart pounding/racing
__ Chest pain
__ Trembling/shaking
__ Sweating
__ Chills/hot flashes
__ Tingling/numbness
__ Fear of dying
__ Fear of going crazy
__ Nausea
__ Phobias
__ Obsessions/compulsive behaviors
__ Thoughts racing
__ Can't hold onto an idea
__ Easily agitate
__ Excessive behaviors (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 and/or alcohol
__ Excessive use of prescription medications
__ Blackouts
__ Physical abuse issues
__ Sexual abuse issues
__ Spousal abuse issues
__ Other problems/symptoms:

_____

_____

_____

_____

_____

Previous outpatient therapy? _____ Yes _____ No, with _____
__ therapy What was accomplished? _____
__ medications, list: _____
Previous hospitalization? ____ Yes ____ No Number of hospitalizations ____ ECT? ____
If yes, when _____