

# San Tan Counseling

## PERSONAL HISTORY, INITIAL ASSESSMENT, AND MASTER TREATMENT FORM

This form will be kept completely confidential and to be used for treatment between you and your counselor. Any information on this form is to be used only as described by National Privacy Act and disclosed only as described in your Client Agreement form.

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Relationship to client \_\_\_\_\_ How did you learn about our services? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Psychiatric Physician \_\_\_\_\_

Insurance \_\_\_\_\_ Employer \_\_\_\_\_

Educational level:  HS  GED  College Other: \_\_\_\_\_

Please check (√) any of the following that you are currently struggling with:

**Relational Difficulties**

- Marital/Partner problems
- Communication problems
- Remarried family problems
- In-laws
- Problems with your parents
- Brother / Sister problems
- Sexual Relationship problems
- Separation
- Divorce
- Dating
- Premarital Issues

**Physical/Health Problems**

- Headaches
- Stomach problems
- Physical disability
- Bed-wetting
- Eating problems
- Sleep problems
- Pain \_\_\_\_ (Scale 1 lowest to 10 highest)

**Children**

- Child's misbehavior
- Child having problems
- Parenting issues
- Parent-child conflict (self)
- Parent-child conflict (spouse/partner)

**Emotional Difficulties**

- Depression
- Suicidal thoughts
- Suicidal actions
- Sadness
- Unhappiness
- Nervousness or panic attacks
- Anger/Temper

**Situation Difficulties**

- Death of a loved one
- Violence (real or threatened)
- Physical abuse (past or current)
- Sexual abuse (adult or child)
- Legal Problems
- Major losses / difficult changes
- Stress
- My past
- Friends
- Religion / Spiritual Concerns
- Decision making

**Personality Concerns**

- Fears
- Low self-esteem
- Loneliness
- Shyness
- Sexuality issues
- Guilt

**Work / School Related Issues**

- Unemployed
- Job / school problem
- Education

- Confusion
- Assertiveness
- Relaxation
- Self-control

**Personality Concerns (cont.)**

- Finances
- Career choices
- Learning disability

- My thoughts
- Addictive behaviors
- Alcohol / Drug use or abuse

**Problems with Coping**

**Sleep Problems**

- Difficulty falling asleep
- Waking in the middle of the night
- Waking too early
- Sleeping too much
- Nightmares

**Change in appetite**

- Gaining weight (specify \_\_\_\_\_)
- Losing weight (specify \_\_\_\_\_)
- Not hungry or not eating
- Throwing up after eating
- Feeling sick to my stomach

**Moody or crying more than usual**

- Difficulties concentrating
- Problems remembering things
- Withdrawing from others
- Panic attacks
- Repeated actions I can't stop
- Can't stop washing hands /body, counting or checking things
- People picking on me
- Self-harm
  - I cut myself
  - I burn myself
  - I hit myself

**Constipation or diarrhea**

- Feeling guilty, worthless, or hopeless
- Fatigue / low energy
- Hyper / too much energy
- Loss of interest in things
- Disturbing thoughts I can't stop
- Extreme worry or fears
- Low self-esteem
- Hallucinations
  - I hear things that others do not
  - I see things that others do not
  - I smell things that others do not
  - I feel things that others do not

**Please list the three items that are causing you the MOST difficulty:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Have you ever seen a counselor before?**  Yes  No

When	Where	How Long	What Reason

**List Any Previous Suicide Attempts**  Yes  No

---



---

Have you recently been thinking about hurting or killing yourself?  Yes  No  
Have you recently been thinking about hurting or killing someone else?  Yes  No

**List any health problems for which you are currently receiving treatment:**

---

---

---

---

**Are you presently taking any medications?**  Yes  No

Medication name                      Dosage

Medication name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Describe any current use of alcohol / drugs including type, amount, frequency of use, and duration (for how long? (if none, write "None").** \_\_\_\_\_

---

---

---

---

**Does anyone in your family have a history of mental health or substance abuse history?**  Yes  No  
Please list:

---

---

---

---

**Are there any traumatic events or abuse that your counselor should be aware of?**  Yes  No  
Please explain: \_\_\_\_\_

---

---

---

---

**Are you involved in any legal proceedings?**  Yes  No

Briefly describe: \_\_\_\_\_

---

---

**Are there any financial issues that your counselor needs to be aware of?** (Bankruptcy, credit card debt etc)  Yes  No \_\_\_\_\_

---

---

**What is your religious preference?** \_\_\_\_\_

**Please list family, friends, support groups or others who are helpful to you**

---

---

---

**Recreational activities** \_\_\_\_\_

---

---

**Your Goals In Counseling**

Goals are very important in counseling. They provide us with a focus and direction that will help us help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Any additional information that you believe would be helpful for your counselor

---

---

---

---

---

Thank you for your assistance in creating your treatment plan. Your signature below indicates your participation in the development of your treatment plan.

\_\_\_\_\_  
Signature of client:

\_\_\_\_\_  
Date: