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: _____

Reason(s) you are here

_____

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

Name: _____

- ❑ **Work / School Relates Issues**
  - ☐ Unemployed
  - ☐ Job / school problem
  - ☐ Education
- ❑ **Personality Concerns** (cont.)
  - ❑ Finances
  - ❑ Career choices
  - ❑ Learning disability
- ❑ Confusion
- ❑ Assertiveness
- ❑ Relaxation
- ❑ Self-control
- ❑ 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
- ❑ 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
- ❑ Change in appetite
  - ❑ Gaining weight (specify _____)
  - ❑ Losing weight (specify _____)
  - ❑ Not hungry or not eating
  - ❑ Throwing up after eating
  - ❑ Feeling sick to my stomach
- ❑ 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

_____ Name: _____

_____

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

Name: _____

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

_____

_____

_____

_____

Are you presently taking any medications? ❑ Yes ❑ No

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? _____

Name: _____

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: