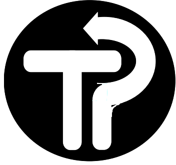

A Turning Point

INITIAL ASSESSMENT

Client Name________________________________ Date____________________

What type of issues have brought you in today? (Circle all that apply)

Individual, Marital, Family, Child, Adolescent, Teen, Parenting, Substance Abuse, Addictions, Intervention, Fears or Phobias, Probation/Legal, Other__________________________________

Briefly describe your purpose or goal in coming in today:

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Please circle those areas you want to address:

higher self-esteem, increased self-confidence, better communication skills, reduced anxiety, reduced depression, increased assertiveness, less self-defeating thoughts and behaviors, resolution of grief issues, stress reduction, better parenting skills, closer marital relationship, conflict resolution skills, boundary-setting abilities, resolution of family-of-origin issues, achievement of sobriety from substance use, stop smoking, lose weight, maintenance of, sobriety, overcome fears, increased positive thinking, make decisions about relationships,

Other____

Please circle any below which you have felt to any significant degree in the last 30 days:

feel depressed, feel anxious, low self-esteem, home stress, work stress, marital stress, no appetite, loss of energy, feel hopeless, fatigue, trouble concentrating, headaches, nausea, nightmares , no motivation, sleep too much, nervousness, hyperactivity, insomnia, increase in appetite, stomach trouble, excessive drinking, drug use, feel tense, feel panicky, take sedatives, unable to relax, sexual problems, suicidal ideas, worried about the future, unable to have a good time, shy with people, don't like weekends and vacations, can't make friends, feel lonely, can't make decisions, can't keep jobs, fearful, self-criticizing, academic problems, financial stress, family problems. Other____