# Self Assessment

Name _____ Date _____

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
- ☐ tinglinging / numbness
- ☐ fear of dying
- ☐ fear of going crazy
- ☐ nausea
- ☐ phobias
- ☐ obsessions / compulsive behavior
- ☐ 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 medication
- ☐ blackouts
- ☐ physical abuse issues
- ☐ sexual abuse issues
- ☐ spousal abuse issues
- ☐ other problems / symptoms

_____

_____

_____

_____

_____

Previous outpatient therapy? ____ No ___ Yes, with _____

____ Therapy, What was accomplished? _____

____ Medications, List _____

Previous hospitalization? _____ No ____ Yes Number of hospitalizations _____ ECT? ____

If yes, when? _____