Linda Lute, LAC, MAC
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CLIENT SELF-ASSESSMENT

Thank you in advance for taking the time to fill out this form. Please answer as honestly as you can. This information is very helpful for my understanding of your situation. The information you provide is confidential.

Client Name: _____ Date:_____
Current Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____ County: _____
Permanent Address, if different from above: _____Apt #: _____
City: _____ State: _____ Zip: _____ County: _____
Home #: (_____)_____ OK to leave message ❑ No ❑ Yes Please Initial _____
Work #: (_____)_____ OK to leave message ❑ No ❑ Yes Please initial _____
Cell #: (_____)_____ OK to leave message ❑ No ❑ Yes Please initial _____

Date of Birth: _____ Age: _____ Sex: _____ SSN #: _____
Race/Ethnicity: _____ Sexual Preference _____
Spiritual/Religious Belief's_____
Years Education Completed _____ Degree (if any) _____
Occupation _____
Employer_____
If not working, are you on disability? ❑ No ❑ Yes If yes, what type? _____
When did you first receive your
disability?_____
Military Service? ❑ No ❑ Yes If yes: ❑ Past ❑ Current
Branch? _____
Relationship Status (please circle): Single Partner Married Separated Divorced Widowed
If marriage or partnership, how long? _ _____

Please list **children and any others**, their ages, and relationship to you living in your home.

_____
_____
_____

If you have minor children who are **not** living with you, please indicate ages and with whom they now live.

_____
_____

Emergency Contact Information
Name: _____ Phone (_____) _____ Relationship_____
Contact Address _____

How were you referred to Life Path? _____

MAIN CONCERNS

Please list the major concerns that you would like help with in therapy, and rate the severity of each concern according to the scale below:

1---------- 2 ---------- 3 ---------- 4

Mild Moderate Severe Couldn't be worse

	Rating	Concern	
1.	_____	_____	_____
2.	_____	_____	_____

Briefly describe what motivated you to seek therapy today (rather than some time earlier or later):

Have you **ever sought counseling before**? _____ yes _____no When?

_____

Was it helpful? ____yes ____no Why or why not?

_____

_____

Please draw a circle around any of the following problems which apply to you in the past two weeks:

Aging	Guilt	Self-control	Unhappiness
Alcohol Use	Headaches	Self-esteem	Other:_____
Anger	Health Problems	Separation/Divorce	_
Anxiety	Insomnia	Sexual Problems	Other:_____
Career Choices	Legal Matters	Sleep	_
Children	Nightmares	Spiritual Needs	Other:_____
Decision Making	Over-commitment	Strange Thoughts	_
Depression	Pain	Stress	Other:_____
Drug Use	Panic Attacks	Stomach Problems	_
Fears	Parenting	Substance Abuse	
Finances	Relationships	Suicidal Thoughts	
Gender Identity	Relaxation		
Grief	School		

HEALTH HISTORY

Name of Primary Care Physician and date last seen:

_____

Current Medical Conditions:

_____

_____

List **prescription and over-the-counter medications** you are currently taking for any conditions, physical or emotional:
(include medications, dosages, times taken)

Have you ever been given a mental health or substance use disorder diagnosis? ❑ No ❑ Yes
If yes, what was it?_____

Is there a family history of mental illness or substance use disorders in your family? ❑ No ❑ Yes
If yes, what types of problem, and which family members?

Have you ever attempted suicide? ❑ No ❑ Yes
Has anyone in your family ever attempted/completed suicide? ❑ No ❑ Yes
If yes, relationship _____
If you have ever been **hospitalized** for emotional problems, please list below how many times, when and where.

Subatance Use
Do you drink coffee? ❑ No ❑ Yes Do you smoke? ❑ No ❑ Yes Do you chew tobacco? ❑ No ❑ Yes
Do you drink soda pop with caffeine (Coke, Mountain Dew, etc.)? ❑ No ❑ Yes
Do you drink alcohol? ❑ No ❑ Yes Do you drink "energy drinks"? ❑ No ❑ Yes
Do you use No Doz or similar caffeine pills? ❑ No ❑ Yes
Do you drink alcohol? ❑ No ❑ Yes
Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes ❑N/A
Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes ❑N/A
How much beer, wine, or hard liquor do you consume each month, on the average?

Which drugs (not medications prescribed for you) have you used in the last 5years? (Please list amounts used at one time and effects)

Do you believe you have a problem with drugs or alcohol? ❑ No ❑ Yes Which one?_____
Have you been affected by someone else's drug/alcohol problem? ❑ No ❑ Yes Please explain.

Have you ever received treatment for any alcohol or drug problem? Please list when and where, if yes.

Do you have any past or current compulsive behaviors? Including drugs, alcohol, eating, shopping, gambling, video gaming, pornography, sex, etc. ❑ No ❑ Yes If yes, please describe.

_____

_____

_____

SOCIAL HISTORY

How would you rate your social life?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, satisfying)
How would you rate your work satisfaction?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, satisfying)

How would you rate your current relationship with your spouse or significant other?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, loving)

How would you rate your current relationship(s) with your parents?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, loving)

How would you rate your current relationship(s) with your children, if any? Or siblings?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, loving)

How important is your faith or spirituality in your life?
(very negative) 1 2 3 4 5 6 7 8 9 10 (very positive, loving)

Do you have any current or pending legal problems? ❑ No ❑ Yes If yes, please describe.

_____

_____

Have you ever been arrested/ convicted/ on probation/parole? ? ❑ No ❑ Yes
DWI/DUI ? (circle one) ❑ No ❑ Yes
If Yes to either question, please describe _____

_____

_____

Are you currently serving, or have you served in the military? ❑ No ❑ Yes If yes, which branch and when?

_____

Are you currently sexually active? ❑ No ❑ Yes Are you experiencing any problems with this part of your life?_____

_____

What are the strengths that help you in your life?

_____

_____

Who is emotionally supportive of you? (family, friends, social groups, church etc.)

_____

_____

What is your biggest fear? _____

_____

What losses, traumas, crises, and transitions have significantly impacted your life (e.g. abuse, divorce, arrests, job changes, moves, death in family, etc.)? What age were you when these changes occurred?

_____

_____

What do you hope to accomplish by coming to therapy, and what do you see as your part in our working relationship?

_____

_____

_____

_____

_____

Client Signature _____ Date _____

Thank you.