BEAUTY FOR ASHES COUNSELING CENTER

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SELF ASSESSMENT

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
__Tingling/numbness
__Fear of dying
__Fear of going crazy
__Nausea
__Phobias
__Obsessions/compulsive behaviors
__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 medications
__ Blackouts
__ Physical abuse issues
__ Sexual abuse issues
__Spousal abuse issues
__Other problems /symptoms :

_____

_____

_____

_____

_____

Previous outpatient therapy?:____Yes ___No
If yes, with therapy what was accomplished?_____
Medications List:_____
Previous hospitalizations: ___Yes ___No Number of hospitalizations:_____
If yes, what hospital and diagnois?:_____