DESERT STREAMS Christian Counseling
Quality Counseling Integrated with Faith

INITIAL ASSESSMENT **Date** _____

Name _____ **Sex: M F** **Social Security #: xxx-xx-**_____
Address _____ **Date of Birth** _____ **Age** _____
City _____ **ST** _____ **Zip Code** _____ **Home Phone** _____
Employer _____ **Work Phone** _____
Email Address _____ **Cell Phone** _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Emergency Contact _____ **Relationship** _____ **Phone** _____

Your hope for counseling? _____
_____
_____
_____

Is there anyone you want involved in your counseling? (ex: spouse, pastor, teacher, etc.) _____
_____

EMPLOYMENT HISTORY

Current Employer _____ **Length of employment** _____
Position/Title _____ **Job satisfaction** _____

EDUCATIONAL HISTORY

Highest grade completed? _____ **Name of school** _____
Area of study _____ **Do/did you like school?** ☐ No ☐ Yes **Explain** _____
_____
Describe school performance _____
Have you ever been diagnosed with a learning disability? ☐ No ☐ Yes **Explain** _____
Have you ever been diagnosed with ADD/ADHD? ☐ No ☐ Yes

MILITARY HISTORY

Were you in the military service? ☐ No ☐ Yes **Branch** _____ **Enlisted?** _____ **Drafted?** _____
Tour _____ **Dates Served** _____ **Combat** ☐ No ☐ Yes **Stationed** _____
Type of discharge _____

LEGAL SYSTEM INVOLVEMENT

Have you ever been involved with the legal system? ☐ No ☐ Yes **If yes, please explain** _____
_____
_____

MARITAL/RELATIONSHIP HISTORY

Current Spouse's / Partner's Name _____ **Age** _____ **Length of Relationship** _____
Were you previously married? ☐ No ☐ Yes **Was your spouse/partner?** ☐ No ☐ Yes

CHILDREN

Name	Age	Relationship	Lives with you?
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes
		☐ biological ☐ step ☐ adopted	☐ No ☐ Yes

FAMILY HISTORY

Father's Name _____ **Age** _____
Education _____ **Occupation** _____
Mother's Name _____ **Age** _____
Education _____ **Occupation** _____
Marital status of parents: _____

Step Father's Name _____ **Age** _____
Education _____ **Occupation** _____
Step Mother's Name _____ **Age** _____
Education _____ **Occupation** _____

Where were you born? _____ **Who raised you?** _____
Were you adopted? ☐ No ☐ Yes **If yes, at what age?** _____

BROTHER'S & SISTER'S (full, half or step)

Name	Age	Occupation	Marital Status

Have you or any member of your family experienced any of the following? (check all that apply)

ADDICTIONS

☐ **Alcohol: Who?** _____
☐ **Drugs: Who?** _____
☐ **Food/Eating: Who?** _____
☐ **Gambling: Who?** _____
☐ **Sex/Pornography: Who?** _____
☐ **Relationship/Love: Who?** _____
☐ **Other** _____ **Who?** _____

EMOTIONAL PROBLEMS

☐ **Depression: Who?** _____
☐ **Anxiety: Who?** _____
☐ **Panic Attacks: Who?** _____
☐ **Manic/Depression: Who?** _____
☐ **Obsessions: Who?** _____
☐ **Suicide attempts or completion: Who?** _____
☐ **Phobia/fears: Who?** _____
☐ **Anger/Explosive: Who?** _____
☐ **Other** _____ **Who?** _____
Have you or any member of your family been hospitalized for any of the above? ☐ No ☐ Yes
If yes, who? _____

ABUSE: (to self/family members)

☐ **Physical: Self/Family?** _____ **by whom?** _____
☐ **Emotional: Self/Family?** _____ **by whom?** _____
☐ **Sexual: Self/Family?** _____ **by whom?** _____
☐ **Spiritual: Self/Family?** _____ **by whom?** _____
Did you ever witness violence in your home or elsewhere while growing up? ☐ No ☐ Yes **If yes, explain** _____
_____
_____

PHYSICAL, PSYCHOLOGICAL AND SOCIAL HISTORY

Physician's Name _____**Name of Practice** _____
Address _____ **Phone** _____
Date of last visit _____ **Reason** _____
List any current or past medical conditions _____
_____
_____
List any surgeries and dates _____
_____
_____
List all current medications (dosage, frequency and purpose) _____
_____
_____
List any allergies _____
_____
List past use of medications for depression, anxiety, ADD/ADHD, sleep, weight control, smoke cessation, etc.? _____
_____
_____
Do you drink alcohol? ☐ No ☐ Yes **If yes, how much and how often?** _____
_____
Do you smoke cigarettes or chew tobacco? ☐ No ☐ Yes **If yes, how much and how often?** _____
_____
Do you consume caffeine? ☐ No ☐ Yes **If yes, how much and how often?** _____

CURRENT SYMPTOM CHECKLIST

Are you currently experiencing any of the following? (check all that apply)

☐ Anxiety/Nervousness	☐ Anger	☐ Bad dreams/nightmares	☐ Compulsive Behaviors
☐ Crying often	☐ Depression	☐ Easily annoyed	☐ Violent Thoughts
☐ Mood Swings	☐ Loneliness	☐ Loss of Hope	☐ Trouble Managing Money
☐ Obsessive Thoughts	☐ Problem in Relationships	☐ Weight Loss or Gain	☐ Racing Thoughts
☐ Sexual problems	☐ Panic Attacks	☐ Trouble Concentrating	☐ Trouble Sleeping
☐ Irritable Bowel	☐ Work Problems	☐ Fatigue	☐ School Problems
☐ Headaches	☐ Low Self Esteem	☐ Social Withdrawal	☐ Backaches
☐ Seizures	☐ Restlessness	Other: _____	

Describe any losses that you have experienced (i.e. health issues, death, divorce, pregnancy loss, retirement, moves, etc.)

_____

_____

_____

PREVIOUS COUNSELING

Have you ever had formal counseling? ☐ No ☐ Yes **How many times?** _____

With whom? _____

When? _____

Why? _____

Was it inpatient or outpatient? _____

Was it helpful? ☐ No ☐ Yes **Explain** _____

_____

_____

Describe the last major change in your life _____

_____

_____

HISTORY

Do you have people in your life that you consider close friends? ☐ No ☐ Yes

When going through a difficult experience in your life do you have someone to confide in? ☐ No ☐ Yes

What activities/hobbies do you enjoy participating in? _____

_____

Are you a member of any groups or organizations? ☐ No ☐ Yes **Explain** _____

_____

_____

List two strengths about yourself _____

_____

_____

List two things about yourself that you would like to change _____

_____

_____

SPIRITUAL HISTORY

Are you affiliated with a church? ☐ No ☐ Yes
If yes, which church? _____ Pastor's name _____
How involved are you in the congregation? _____
Attendance: ☐ Never ☐ Sometimes ☐ Regularly

ADDITIONAL INFORMATION

What else should your therapist know about you? _____
_____
_____
_____
_____
_____

Therapist _____ Date of assessment review _____