PLESHE COUNSELING SERVICES
ASSESSMENT PART 1

PERSONAL HISTORY

Name:_____ Date of Birth:_____ Age:_____ Sex: M F
Place of Birth:_____ Who Referred You:_____

Personal Status:

_____ Married (Please specify length)
_____
_____ Long Term Committed Relationship (Please specify length)
_____
_____ Single
_____ Widowed (When)
_____
_____ Divorced
Date 1.) _____ Reason: _____
Date 2.) _____ Reason: _____
Date 3.) _____ Reason: _____
_____ Engaged (Expected date of Marriage if known)
Date: _____
Describe any difficulties in current relationship (please include mental health or drug issues):_____
_____

YOUR CURRENT DIFFICULTIES (Identified by you or others close to you)

Check all that apply

_____ **Eating Issues** (Please specify type): _____
_____ **Emotional Intimacy**
_____ **Sexual Intimacy**
_____ **Fertility**
_____ **Parenting**
_____ **Addictions** (Please specify): _____
_____ **Family Tension**
_____ **Communication**
_____ **Emotional Abuse**
_____ **Physical Abuse**
_____ **Sexual Problems**
_____ **Drug/Alcohol Addiction**_____
Treatment history (please note type of addiction and details):
_____

_____

DWI or OWD (list any)

_____

_____**Work**

_____**Depression** Circle: Chronic Situational Not Sure

Suicide Attempts (Please specify)
Date: _____
Type of Attempt: _____
_____
Related Hospitalization: _____
_____

Date: _____
Type of Attempt: _____
_____
Related Hospitalization: _____
_____

Date: _____
Type of Attempt: _____
_____
Related Hospitalization: _____
_____

Current Suicide Ideation/Potential (Please Rate)
_____None _____Low _____Medium _____ High _____ Very High
What Currently keeps you safe:
_____

_____ **Anxiety**
_____ **Body Image**
_____ **Trauma** (Examples include: childhood emotional, physical, or sexual abuse, abandonment, motor vehicle accidents, death of a loved one, military service, life threatening situation, or other)
Please list any events in your life you believe to be traumatic with approximate date of occurrence.
Date _____
_____
_____
_____
Date _____
_____
_____
_____

_____ **Low self-esteem**

Please add any additional information re: any of the items checked above:
_____
_____
_____

Medications: Please list any/all you are taking and indicate what they are for:
_____ _____
_____ _____
_____ _____
_____ _____

Prescribing Physician: _____

MORE PERSONAL HISTORY

Children:

Biological

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

Adopted or Step Children (Please circle which applies)

Name: _____ (Ad/S) Date of Birth: _____
Name: _____ (Ad/S) Date of Birth: _____
Name: _____ (Ad/S) Date of Birth: _____
Name: _____ (Ad/S) Date of Birth: _____

Your Parents: Please give full name of both.

Mother: _____ Living? Age: ___ Deceased? Date: ___
Father: _____ Living? Age: ___ Deceased? Date: ___
If Divorced: Please provide how old you were when they divorced: _____
If Remarried: Please provide when and how long if known:
(Mother): _____
(Father): _____

Brothers and Sisters: List names and ages (if step sibling please mark with SS next to name)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Other Pertinent Information
Current Occupation and Job title: _____
How long with present employer: _____
Significant Previous Employment: _____
Educational History:
High School Attended _____ Grad. Date ____
College Attended/Degree _____ Grad. Date ____
Secondary/Technical School _____ Grad. Date ____

MEDICAL HISTORY
Primary Physician: _____
(Please provide a brief statement regarding the following)
Hospital/Surgeries:
_____
_____

Serious Illness/Injuries:
_____
_____
Chronic Medical Conditions:
_____
_____
Current prescriptions/medications (other than mental health prescriptions):
_____
_____
Other medical problems (dizziness, fainting, headaches, hyperactivity, bed wetting, etc.)
_____
_____
Weight gain/loss in past 6 months:
_____
Smoking (How much): **Caffeine** (How much):
_____ _____
Date of last physical:
_____
Describe your sleep pattern:
Go to bed at: Wake up at:
_____ _____
Other problems sleeping:
_____
_____

Previous Psychiatric, AODA, Mental Health Treatment (Inpatient/outpatient, where, when, reason)

_____
_____
_____

SOCIAL/COMMUNITY FUNCTIONING

Educational History:

Client's level of Education (*Circle highest completed)*:
Elementary High College Graduate
Other: _____

Legal History:

Pending court dates: _____
Drunk driving arrests: _____
Other arrests: _____
Have the police been called for domestic abuse? (*Please circle)* Yes or No
If yes, please give date(s): _____

Occupational History:

(Please circle Yes or No for each of the following)
In the past year, have you missed 0-6 days of work? Yes or No
More than 7 days of work? Yes or No
Has work performance affected employment during past 5 years? Yes or No
Has your current problem affected your ability to work? Yes or No
If you answered "yes" to any of the above, please explain:
_____
_____
_____

Spirituality:

Please describe your/your family's spiritual/religious practices and affiliations:
_____
_____
_____
What do you value most in life?
_____
_____

PERSONAL STRENGTHS

What do you like most about yourself?

_____
_____
_____
_____

FAMILY EVALUATION

What issues are causing the most stress for you and/or your family?

_____
_____
_____

QUESTIONNAIRE

Date completed: _____

Read each item carefully and circle the number that best describes your present situation:	**0**: Not Applicable **1**: Not at All **2**: A little			**3**: Moderate **4**: Quite a bit **5**: Extremely		
I am experiencing feelings of depression.	**0**	**1**	**2**	**3**	**4**	**5**
I feel sad.	**0**	**1**	**2**	**3**	**4**	**5**
I enjoy participating in physical or social activities.	**0**	**1**	**2**	**3**	**4**	**5**
I feel worthless/rejected.	**0**	**1**	**2**	**3**	**4**	**5**
I am unconcerned about my personal appearance and good health habits.	**0**	**1**	**2**	**3**	**4**	**5**
I feel tired or fatigued.	**0**	**1**	**2**	**3**	**4**	**5**
I feel hopeless about the future.	**0**	**1**	**2**	**3**	**4**	**5**
I have crying spells.	**0**	**1**	**2**	**3**	**4**	**5**
I feel emotionally numb.	**0**	**1**	**2**	**3**	**4**	**5**
I have difficulty concentrating or am easily distracted.	**0**	**1**	**2**	**3**	**4**	**5**
I have difficulty making decisions.	**0**	**1**	**2**	**3**	**4**	**5**
I have a hard time handling family responsibilities.	**0**	**1**	**2**	**3**	**4**	**5**

I have a hard time functioning as an independent person (managing life in general)	**0**	**1**	**2**	**3**	**4**	**5**
I am irritable or restless.	**0**	**1**	**2**	**3**	**4**	**5**
I am easily angered.	**0**	**1**	**2**	**3**	**4**	**5**
I feel anxious.	**0**	**1**	**2**	**3**	**4**	**5**
I have to avoid certain places or situations because of being afraid.	**0**	**1**	**2**	**3**	**4**	**5**
I have strong feelings for no apparent reason.	**0**	**1**	**2**	**3**	**4**	**5**
I have periods of excessive worry.	**0**	**1**	**2**	**3**	**4**	**5**
I have strong mood swings (highs and lows).	**0**	**1**	**2**	**3**	**4**	**5**
I have strong feelings of fear.	**0**	**1**	**2**	**3**	**4**	**5**
I have strong feelings of anger.	**0**	**1**	**2**	**3**	**4**	**5**
I have strong feelings of guilt.	**0**	**1**	**2**	**3**	**4**	**5**
I have a difficult time controlling myself.	**0**	**1**	**2**	**3**	**4**	**5**
I have a difficult time staying out of trouble.	**0**	**1**	**2**	**3**	**4**	**5**
I have repetitive or uncontrolled thoughts.	**0**	**1**	**2**	**3**	**4**	**5**
I engage in repetitive behaviors to calm myself.	**0**	**1**	**2**	**3**	**4**	**5**
I am having a hard time dealing with the loss/death of an important relationship.	**0**	**1**	**2**	**3**	**4**	**5**
I have a hard time forming or sustaining close relationships.	**0**	**1**	**2**	**3**	**4**	**5**
I am having a hard time dealing with the emotional problems of a family member or friend.	**0**	**1**	**2**	**3**	**4**	**5**