Transitions Counseling

ASSESSMENT

Client Name _____ **D.O.B.** _____ **Age** _____

Marital Status _____ **How Long** _____

Number of Children / Ages _____

Occupation _____ **How Long?** _____

Are You Happy with your current Occupation _____ **If no, Explain** _____

Why did you seek counseling? _____

_____

What resolution / goals are you seeking from counseling?

_____

_____

_____

Any Previous Counseling _____ **When and who with** _____

Why _____

Current Medications _____

Medical History / Hospitalizations / Current Medical Problems

_____

_____

Do You Use Drugs _____ **Which Drugs** _____

Transitions Counseling

ASSESSMENT

How often _____ Last Use _____

Do You Drink Alcohol _____ What Type _____ How Often _____

Are Drugs or Alcohol Causing Problems In Your Life _____

How so_____

Highest Grade Completed _____ Have You Ever Been Arrested _____

Current Legal Status _____

On a scale of 1 – 10 (1 being unhappy & 10 being overjoyed) How happy are you with your life right now _____

_____

Are you feeling depressed _____ Any history of depression _____

Are you having anxiety / panic attacks _____ In the Past _____

Are you having trouble sleeping _____ Explain _____

Eating Habits _____

Do you find yourself worrying a lot _____ Explain _____

Do You Get Angry Often _____ If Yes Explain _____

What are your biggest life stressors _____

_____

Are you the survivor of a type of Abuse ____ If Yes please explain the type, when and by whom you were abused.

Physical _____

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Emotional _____

Sexual _____

Have you ever attempted suicide / Self Harm _____ **If Yes please explain details** _____

_____

_____

ARE YOU CURRENTLY HAVING THOUGHTS OF SUCIDE _____

Family History / Dynamics:

Who raised you _____

Number of Siblings / Birth order _____

What was your childhood like

_____

_____

_____

Significant Deaths / Losses in your life and when

_____

_____

_____

Hobbies / Activities / Recreation / What you do for Fun

_____

_____

_____

ASSESSMENT

Spiritual Practices

_____

Church or Religious Attendance _____ How Often _____

Greatest Strengths You Have

_____

_____

_____

Greatest personal challenges in your life

_____

_____

_____

STOP HERE: ADDITIONAL INFORMATION TO BE COMPLETED BY THERAPIST

Transitions Counseling

ASSESSMENT

Needs Assessment:

Biological _____

_____

Safety / Security

_____

_____

_____

Love/Belonging:

_____

_____

_____

_____

Esteem/Respect:

_____

_____

_____

_____

Purpose:

_____

_____

_____

ASSESSMENT

Therapy Goals:

_____

_____

_____

_____

_____

_____

Diagnosis: _____ _____

_____ _____

Therapist: _____ **Date** _____

Therapist: _____ **Date** _____