Name: _____ Date: _____ DOB_____

INITIAL ASSESSMENT/CONSULTATION

Please answer the following questions truthfully and complete as possible. Your answers will help your individualized treatment planning or consultation (if applicable) at **Chat N Relax Counseling & Consultation, LLC**.

TREATMENT_____

1. **Please check the reason(s) for your visit today?**

__ Anger Management __ Anxiety __ Depression __ Grief __ Relationship Issues

__ Moodiness __ Post-Traumatic Stress Disorder __ Substance Use/Abuse/Dependence

__ Other: _____

2. **Please list any previous mental health and/or substance use treatment. (Location/Year)**

_____

_____

_____

3. **Please list any current or past treatment with a psychiatrist. (Doctor, Year, & Reason)**

_____MD _____YEAR _____ Reason

_____MD _____YEAR _____ Reason

_____MD _____YEAR _____ Reason

4. **Have you ever had thoughts of suicide? Y or N If yes, when**:_____

   Have you ever had any previous attempts or plans of suicide? Y or N If yes, please explain:_____

   _____

5. **Have you ever had thoughts or plans to hurt or harm others? Y or N If yes, please explain:** _____

   _____

6. **Any past physical, emotional, or mental trauma history experienced that has significantly impacted your mental health? Y or N If yes, please explain**:

   _____

7. **Have you ever been <u>screened or hospitalized for a mental health or psychiatric concern</u>? Y or N If yes, please provide hospital information on next page.**

Name: _____ Date: _____ DOB_____

INITIAL ASSESSMENT/CONSULTATION

HOSPITAL	YEAR	REASON

EDUCATION_____

8. **Do you have a High School Diploma or GED? Y or N**
9. **Do you have a college degree? Y or N If yes, major/degree** _____

High School _____ Years _____- _____

College _____ Years _____-_____

Vocational/Trade School _____

EMPLOYMENT _____

10. **Are you currently employed? Y or N** FULL TIME PART TIME TEMP/SEASONAL
11. **Name of Employer: _____**
12. **Job Title: _____**
13. **Do you have a profession, trade, or skill? Y or N If yes, specify: _____**

ADOLESCENT/MINORS (17yrs & under)

14. Grade: _____ School: _____
15. How are you performing in school? _____
16. Have you ever experienced bullying or being bullied? _____
17. Do you feel you have a positive or good support by family, friends, loved ones? Y or N
18. How many close friends you have? _____
19. Do you enjoy daily activities such as hanging out with friends, family, doing your favorite hobby, etc.? Y or N

Name: _____ Date: _____ DOB_____

INITIAL ASSESSMENT/CONSULTATION

20. Please circle any of the following that you may have experienced in the past:

Depression Anxiety Sadness Anger Lack of Support Abuse Thoughts of hurting self Thoughts of hurting others Physical Fighting Violence Law Enforcement Moodiness Eating Disorder Attempted Suicide Drugs Trauma Grief Transitional/Adjustment

Other: _____

LIFE & FAMILY HISTORY_____

21. **Gender:** _____ **Sexuality:** _____ or **Ask Me** ☐
22. **Marital Status:** ___Single ___Married ___Divorced ___Dating/Relationship ___Separated
23. **Who lives with you?** _____
24. **Do you have any children? Y or N** If yes, gender & ages: _____

    _____

25. **Who do you have the closet relationship with in your life?** _____
26. **Who do you have the most difficult relationship with?** _____
27. **Do you have an active positive social life? Y or N**
28. **Are you able to maintain healthy relationships? Y or N**
29. **Any history of**: **Emotional** Abuse Y or N, **Verbal** Abuse Y or N, **Physical** Abuse Y or N **Sexual** Abuse Y or N, **Discriminatory/Neglect** Abuse Y or N
30. **Any general comment or statement about your family and/or life**? _____

    _____

MEDICAL HISTORY_____

31. **Any general medical conditions, diagnoses or allergies? Y or N** If yes, please explain:

    _____

32. **Any medical condition(s) related to substance use/abuse?** Y or N
33. **Any physical, mental, or learning disabilities?** Y or N _____
34. **Primary Doctor:** _____

Name: _____ Date: _____ DOB_____

INITIAL ASSESSMENT/CONSULTATION

35. **Are you taking any prescribed medications? Y or N** *If yes, please specify medication, dosage, prescribed for, and prescribing doctor on next page.*

36.

MEDICATION	DOSAGE	FOR	DOCTOR

37. **Describe your appetite** (eating habits)_____
38. **Describe your sleeping** _____ Average hours of sleep a night_____
39. **Are you sexually active?** Y or N If yes, do you use protection/contraceptives _____

SUBSTANCE USE HISTORY_____

40. **Please indicate if you use/do any of the following**: ___Cigarettes ___Vape ___Other
If yes, how many daily _____

41. **Please indicate substance use history below (if applicable):**

SUBSTANCE	AGE 1st use	Amount	Frequency	Last Use	Route
Alcohol					
Amphetamines					
Barbiturates					
Benzodiazepines					
Cannabis					
Cocaine					
Ecstasy					
Hallucinogens					
Heroin					
Inhalants					
K2/Spice					
Ketamine					
Methamphetamine					
Methadone					
Other Opiates					

Other Sedatives					
OTHER_____					
Over the Counter					

42. **Have you ever overdosed? Y or N** If yes, when_____
Was Narcan administered? Y or N

43. **Have you participated in a substance use program in the past?** Y or N If yes, location & year below:

_____

_____

44. **Have you ever had a period of sobriety?** Y or N; N/A If yes, how long? _____
If yes, why did you relapse? _____

LEGAL_____

45. Any current or pending legal issues, court cases, or charges? Including DCP&P? Y or N Explain:

_____

46. **Are you currently on probation or paroled? Y or N** If yes, explain:

_____

Name, address & phone number of Probation/Parole Officer: _____

_____

47. **Do you have an Advance Medical or Psychiatric Directive? Y or N** If yes, who?

_____

48. What would you like to accomplish in counseling?

_____

_____

By signing below, I acknowledge my answers are truthful and recalled to the best of my knowledge.

_____ _____

(Client Signature) (Date)

_____

(Parent/Guardian Signature if applicable)