



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 screened or hospitalized for a mental health or psychiatric concern? Y or N If yes, please provide hospital information on next page.



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<u>HOSPITAL</u>	<u>YEAR</u>	<u>REASON</u>

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



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20. Please circle any of the following that you may have past or present issues with:

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
Self-Esteem Sexuality 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 closest 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:** _____



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

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



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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)