

Self Assessment

Your name: _____

Date: _____

What is happening in your life now, which results in this appointment? _____

How long have you had these concerns? _____

How have you attempted to deal with your concerns? _____

CHECK ALL OF THE COMPLAINTS LISTED BELOW THAT APPLY TO YOU

Depression	Low energy	Low self-esteem
Poor concentration	Hopelessness	Worthlessness
Guilt	Shame	Sleep disturbance (more or less?)
Appetite disturbance (more or less?)	Starting too many projects, finishing none	Loss of energy
Isolation/Social Withdrawal	Sadness	Death of family member, spouse, or friend
Stress/Tension	Anxiety/Panic	Heart pounding/racing
Chest pain	Trembling/shaking	Sweating
Chills/hot flashes	Tingling/numbness	Fear of dying
Racing thoughts	Unrealistic beliefs/hallucinations	Unrealistic or problematic fears
Excessive behaviors (gambling, spending)	Feeling disconnected from self/not real	Feeling disconnected from things around you
Loss of time	Persistent and/or unpleasant thoughts	Easily angered/frustrated
Defy rules	Blame others	Argumentative
Excessive use of drugs or alcohol	Blackouts	Physical abuse issues
Sexual abuse issues	Emotional abuse issues	Domestic violence
Confusion	Easily agitated	Disconnected thoughts/ideas
Obsessions/compulsive behaviors	Following or stalking someone	Nightmares/bad dreams
Work problems	Social problems	Family problems

Are you currently having thoughts of self-harm? Yes No If yes, please describe what your intentions are: _____

Are you currently having thoughts of harming someone else? Yes No If yes, please describe what your intentions are: _____