

SELF ASSESSMENT

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Client's Name: _____

What is happening in your life which resulted in this appointment? What would you like to see accomplished in therapy?

Chief Complaint(s). Check all that apply:

- Depression
- Low Energy
- Low Self Esteem
- Poor Concentration
- Hopelessness
- Worthlessness
- Guilt
- Sleep Disturbance (more/less)
- Chest pain
- Appetite Changes (more/less)
- Thoughts of hurting yourself
- Thoughts of hurting someone
- Isolation/Social Withdrawal
- Sadness/Loss
- Stress
- Anxiety/Panic
- Heart pounding/racing
- Phobias
- Excessive behaviors (spending, gambling)
- Delusions/hallucinations
- Can't hold onto an idea
- Easily agitated
- Confusion/unclear thinking
- Feeling you're not real
- Fear of dying
- Fear of going crazy
- Trembling/shaking
- Sweating
- Chills/hot flashes
- Tingling/numbness
- Nausea

- ___ Feeling that things around you are not real
- ___ Lose track of time
- ___ Unpleasant thoughts that wont go away
- ___ Anger/frustration
- ___ Defies rules
- ___ Blames others
- ___ Argues
- ___ Excessive use of alcohol, drugs (illegal or legal prescription)
- ___ Blackouts
- ___ Physical abuse issues
- ___ Sexual abuse issues
- ___ Obsessions/compulsive behaviors
- ___ Spousal abuse issues

Other problems and symptoms: _____

THERAPY HISTORY

Previous therapy? _____

What was accomplished? _____

Previous hospitalizations? _____

If yes, number of hospitalizations? _____ If yes, when? _____ What was the reason? _____

MEDICAL HISTORY

Last medical exam: _____

Any current medical problems you are experiencing or currently being treated for: _____

List any current medications: _____

EDUCATIONAL HISTORY

List all previous school and educational experiences, including high school, college, vocational schools, etc.

EMPLOYMENT HISTORY

List your current employment, career and a brief outline of your employment history:

SOCIAL SKILLS

List clubs, organizations, and communities you are involved in:
What do you do for self care, relaxation and pleasure?