nancy lowrie and associates LLC

SELF ASSESSMENT

CLIENT NAME (PRINT)_____ DATE _____

CLIENT SIGNATURE _____COMPLETED BY: _____

What is happening in your life which resulted in this appointment?

_____

_____

_____

What would you like to see accomplished in therapy?

_____

_____

_____

CHECK ALL THAT APPLY TO YOU:

___Depression
___Low Energy
___Low Self-esteem
___Poor Concentration
___Hopelessness
___Worthlessness
___Guilt
___Sleep Disturbance
___Appetite Disturbance (more/less)
___Thoughts of hurting yourself
___Thoughts of hurting others
___Cutting, Injuring Self
___Isolation/Social Withdrawal
___Sadness/Loss
___Stress
___Anxiety/Panic
___Heart Pounding/Racing
___Chest Pain
___Sweating
___Marital Conflict
___Fear of Dying
___Fear of Going Crazy
___Gambling
___Grief, Mourning
___Suicidal, Homicidal Thoughts
___Childhood Memories
___Phobias

___Excessive use of Drugs/Alcohol
___Excessive use of Prescriptions
___Blackouts
___Physical, Sexual, Verbal Abuse
___Spousal Abuse Issues
___Anger/Frustration
___Easily Agitated/Annoyed
___Defies Rules
___Blames Others
___Cannot hold on to an Idea
___Divorce/Separation
___Excessive Behaviors
___Delusions/Hallucinations
___Not Thinking clearly/Confusion
___Feeling that you are Not Real
___Gambling/Spending
___Lose track of Time
___Unpleasant Thoughts won't go away
___Health Issues
___Relationship Issues
___Work Issues
___School Problems
___Legal Matters

___Other problems / symptoms
_____
_____

Clinician Name _____ Date_____