Client Self-Assessment Worksheet

Name: _____ Date of Birth: _____

Relationship to Person Served: _____ Referred by: _____

Family Physician: _____ Dentist: _____

Why are you coming to Northeastern Center; What brings you in today?

_____

Current Symptom Checklist:

None = No symptom present at this time.
Some= Impacts quality of life but does not significantly impair day-to-day functioning.
A lot = Significantly impacts quality of life and day-to-day functioning.
Past = Prior impact on my life and daily functioning.

	None	Some	A lot	Past		None	Some	A lot	Past
Depressed Mood	[ ]	[ ]	[ ]	[ ]	Hallucinations	[ ]	[ ]	[ ]	[ ]
Feel Hopeless/Overwhelmed	[ ]	[ ]	[ ]	[ ]	Delusions	[ ]	[ ]	[ ]	[ ]
Poor Concentration	[ ]	[ ]	[ ]	[ ]	Paranoid Thoughts	[ ]	[ ]	[ ]	[ ]
Social Isolation/withdrawal	[ ]	[ ]	[ ]	[ ]		[ ]	[ ]	[ ]	[ ]
Fatigue/Low energy	[ ]	[ ]	[ ]	[ ]	Appetite Disturbance	[ ]	[ ]	[ ]	[ ]
Grief/Death/Loss	[ ]	[ ]	[ ]	[ ]	Bingeing/Purging	[ ]	[ ]	[ ]	[ ]
Irritability	[ ]	[ ]	[ ]	[ ]	Laxative/Diuretic Abuse	[ ]	[ ]	[ ]	[ ]
Feelings of Guilt	[ ]	[ ]	[ ]	[ ]	**Children 0-17 Years of Age Only**				
Poor Grooming	[ ]	[ ]	[ ]	[ ]	Chronic Lying	[ ]		[ ]	[ ]
Sleep Disturbance	[ ]	[ ]	[ ]	[ ]	Stealing	[ ]		[ ]	[ ]
Suicidal Thoughts	[ ]	[ ]	[ ]	[ ]	Fire Setting	[ ]		[ ]	[ ]
Thoughts of Self Harm	[ ]	[ ]	[ ]	[ ]	Won't Sleep Alone	[ ]		[ ]	[ ]
Self-Harm	[ ]	[ ]	[ ]	[ ]	Not Trustworthy	[ ]		[ ]	[ ]
Anxiety	[ ]	[ ]	[ ]	[ ]	Indecisive	[ ]		[ ]	[ ]
Obsessions/Compulsions	[ ]	[ ]	[ ]	[ ]	Immature	[ ]		[ ]	[ ]
Panic Attacks	[ ]	[ ]	[ ]	[ ]	Bizarre Behaviors	[ ]		[ ]	[ ]
Phobias/Fears	[ ]	[ ]	[ ]	[ ]	Distrustful of others	[ ]		[ ]	[ ]
Defiant behavior	[ ]	[ ]	[ ]	[ ]	Extreme Worrier	[ ]		[ ]	[ ]
Mood Swings	[ ]	[ ]	[ ]	[ ]	Impulsive	[ ]		[ ]	[ ]
Racing Thoughts	[ ]	[ ]	[ ]	[ ]	Cruelty to Animals	[ ]		[ ]	[ ]
Hostile/Angry Mood	[ ]	[ ]	[ ]	[ ]	Temper Tantrums	[ ]		[ ]	[ ]
Confused Thinking	[ ]	[ ]	[ ]	[ ]	Bullying(Victim or Perpetrator)	[ ]		[ ]	[ ]
Self-Injurious Acts	[ ]	[ ]	[ ]	[ ]	Running Away	[ ]		[ ]	[ ]

What are your current stressors/problems? _____

How do you deal with stressors? _____

Describe Your Support System: _____

Describe any Spiritual or Cultural Issues, Needs or Concerns: _____

Describe any risk-taking behaviors or issues: _____

Do you buy Lottery Tickets? ___Yes___No 2) Go to Casinos? ___Yes___No 3) Bet on racing, games, etc? ___Yes No

Has gambling ever caused problems for you in your relationship, legally, or financially? _____Yes _____No

Mental Health History:

Prior outpatient counseling ____Yes_____No Prior inpatient hospitalization ____Yes ____No

Outpatient Provider :_____Treatment Dates: _____

Inpatient Provider:_____Treatment Dates: _____

Diagnoses: _____

Has any family member received mental health outpatient counseling or inpatient hospitalization?_____YES_____NO

Medical/Developmental History: [check all that apply under **S** = **Self** and **F** = **Family**]

S	F		S	F		S	F		S	F	
[ ]	[ ]	Tuberculosis*	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Alzheimer's/dementia	[ ]	[ ]	Hepatitis
[ ]	[ ]	Positive TB Test*	[ ]	[ ]	Heart Disease	[ ]	[ ]	Cancer	[ ]	[ ]	Birth Defects
[ ]	[ ]	Chest Pain w/ deep breath*	[ ]	[ ]	Thyroid Problems	[ ]	[ ]	Diabetes	[ ]	[ ]	Stroke
[ ]	[ ]	Coughing Up Blood*	[ ]	[ ]	Balance Problems	[ ]	[ ]	Problems with balance	[ ]	[ ]	Ulcers
[ ]	[ ]	Ongoing Cough*	[ ]	[ ]	Severe headaches	[ ]	[ ]	Ear infections/tubes			
[ ]	[ ]	Ongoing Fever*	[ ]	[ ]	Frequent Headaches	[ ]	[ ]	Jaundice/yellow skin			
[ ]	[ ]	Chills*	[ ]	[ ]	Convulsions/seizures	[ ]	[ ]	Orthopedic problems			

[ ] [ ] Allergies:_____ [ ] [ ] Injuries: _____

Date of Last Physical Exam:_____Physician: _____

List any current medical conditions you are being treated for: _____

Describe your current physical condition: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Are immunizations up to date?_____YES _____NO

Current Medication/s: (Please list all current medications and dosages):

_____

_____

Side Effects: YES NO Beneficial: YES NO Physician/Address: _____

Prior Medication/s: (Please list prior medications, dosages, and reason for medication/treatment):

_____

_____

Side Effects: YES NO Beneficial: YES NO Physician/Address: _____

Educational History or Status:

Educational level [Grade; Degree; Training Certificate] and School: _____

Does child have an IEP or 504? Yes No

Literacy Level (reading level): ☐ Below age/grade level ☐ At age/grade level ☐ Above age/grade level

More specifics if available: _____

Family History:

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmo	[ ]	[ ]	[ ]
stepfa	[ ]	[ ]	[ ]
brother/s	[ ]	[ ]	[ ]
sister/s	[ ]	[ ]	[ ]
other/s	[ ]	[ ]	[ ]

(specify) :_____

Childhood family experience:

[ ] lived in foster home:____years
[ ] lived with others:____years
[ ] witnessed physical abuse to others
[ ] experienced verbal abuse from others
[ ] experienced physical abuse from others
[ ] experienced sexual abuse from others
[ ] experienced or witnessed neglect
[ ] other:_____

Significant issues_____

Age at leaving childhood home:_____Circumstances: _____

Marital Status:

[ ] Single, never been married
[ ] Married
[ ] Divorced
[ ] Widowed
[ ] Other: _____
Number of Prior Marriages: _____

Sexual History:

Sexual Orientation: _____
Gender Identity: _____
Age of First Sexual Experience: _____
Age of First Pregnancy/Fatherhood: _____
Sexually Transmitted Infections:_____

List all persons currently living in your household

Name	Age	Gender	Relationship to yourself

List any children (Age 0-18yrs) NOT living in your household

Name	Age	Gender	Relationship to yourself

Occupational History:

[ ] employed [ ] retired [ ] unemployed [ ] disabled

Type of Work: _____

Any problems/issues at work? _____

_____

Legal History

Have you ever been arrested? _____Yes ____No

Are you currently on parole/probation/community corrections?_____Yes ____No

Name of Parole or Probation Officer and County: _____

Have you ever been incarcerated?_____Yes ____No

Have you ever been accused of physical or sexual abuse? _____Yes ____No

Describe any other legal difficulties or involvement: _____

_____

Do you have a legal Guardian?_____Yes ____No If yes, Name: _____

Do you have a Power of Attorney?_____Yes ____No ; If yes, Name: _____

Substance Use History:

Have you ever used?	Yes	No	Family History
Alcohol			
Benzodiazepines			
Cocaine/Crack			
Marijuana/Hashish			
Heroin/Non-prescription methadone			
Opiates			
Methamphetamine			
Other Amphetamines/Stimulants			
Barbiturates			
Inhalants			
Over-counter/aspirin/cough syrup			
Misused Prescription Drugs			
Tobacco			
Other: _____			

Substance Use Treatment History:

Prior outpatient counseling ____Yes_____No Prior inpatient hospitalization ____Yes ____No

Outpatient Provider :_____Treatment Dates: _____

Inpatient Provider:_____Treatment Dates: _____

Diagnoses: _____

Has any family member received substances use outpatient counseling or inpatient hospitalization?_____YES ____NO