WHOLE JOURNEY

Confidential Self-Assessment

Name:_____ Date:_____

Current Concerns (What are the main reasons you are seeking help?)

	Primary Issue	Important Issue
Personal/Emotional Issues		
Relationship/Marital		
Job/Career		
Family of Origin Issues		
Child/Parenting Concerns		
Financial Issues		
Health Problems		
Other Life Stressors		

How long have you been experiencing these problems?_____

What have you done to address these problems?_____

_____

_____

What do you think is causing these problems?_____

_____

_____

Have you experienced any major life changes in the past few months?_____

_____

Who lives in your household?

Name	Age	Relationship to You

Significant life trauma(s)/losses: Trauma/Loss

Trauma/Loss	When

Any history of suicidality/homicidality?

Suicide Attempt(s)	Yes	No	How/When?
Current/Recent Suicidal Thoughts	Yes	No	Last time? Plan:
Homicidal/Violent Thoughts	Yes	No	Last time? Describe:

Additional
Comments:_____

_____

_____

Substance Use History

Alcohol Use	Choose One			
Frequency of Use	None	Monthly	Weekly	Daily
How Much?	None	1-2	3-5	More than 5
Drink of Choice	Beer	Wine	Hard Liquor	
Do you think it's a problem?	Yes	No	Unsure	

Other Drug Use Check box below

	Frequency of Use			
Marijuana	None	Occasionally	Weekly	Daily
Other non-prescriptive drug	None	Occasionally	Weekly	Daily
Prescription drugs used not as prescribed	None	Occasionally	Weekly	Daily

If yes, list what substances_____
If yes, what prescriptions_____

Work History

Current Employment Status Check box below

Employed, full-time	
Employed, part-time	
Student	
Self-employed	

Homemaker/stay at home parent	
Retired	
Other Specify:	

Check box below related to employment

Job Satisfaction	Very Satisfied	Moderately Satisfied	Not Satisfied at all

Treatment History

List hospitalizations for medical, psychiatric or chemical dependency problems.

Date	Reason (s)	Hospital

Previous or current therapy or counseling:

EAP or substance abuse treatment: Individual therapy
Marital/couples therapy Group therapy
12-step program Medication management/psychiatrist
Pastoral/religious Provider

Provider/Type of Counseling/Therapy	When	Reason sought treatment

Child and Family History:

Is there a family history of any of these issues?

Substance Abuse (Y/N) Mental Illness (Y/N) Suicide (Y/N)

Name	Relationship to You	Issue

Did you experience any of the following as a child/young adult?

Schoool problems	Yes	No	Age:
Depression	Yes	No	Age:
Substance Abuse	Yes	No	Age:
Legal problems	Yes	No	Age:
Sexual/physical abuse	Yes	No	Age:
Domestic violence	Yes	No	Age:

Did you experience any other major childhood issues? (Yes or No)

Describe_____

_____

_____

Growing up were your parents? (Choose all that apply)
Together/Married Age_____
Divorced/Separated Age_____
Deceased Age_____
Raised by caregiver guardian other than parents If so: who_____

Siblings

Name	Age	Biological, step-sibling, half-sibling or adopted

Symptom Checklist:
Check all that apply to how you have been feeling

	Sleep problems		Memory problems		Hard time sitting still/restless
	Not enjoying things		Loss of time		Worrying a lot
	Problems at work		Racing heart beat		Drug/alcohol use
	Obsessive thoughts		Nervous or tense/unable to relax		Concerns about sexual feelings or identity
	Lack of friends		Relationship problems		Other sexual concerns
	Stomach aches/digestive problems		Shy/uncomfortable around others		Not feeling confident
	Feeling panic and fear		Problems concentrating		Racing thoughts
	Feeling anxious		Grief or loss		Problem eating habits
	Not feeling good enough		Feeling hopeless		Feeling worthless
	Compulsive behaviors		Disturbing thoughts		Not getting along with others
	Wanting to hurt self		Mood swings		Shaking/trembling
	Wanting to harm others		Feelings of wanting to die		Chronic pain
	Aggressive/abusive		Sadness or depression		Childhood issues
	Angry easily or a lot		Confused thinking		Problem staying on task
	Problems with sexual thoughts/behavior		Problems with decision making/judgement		Concerns about family members
	Irritable		Abused by others		Illegal behavior
	Isolating/not wanting to be around others		Impulsive/Doing things without thinking		See or hear things others don't
	Self harm behaviors		Disorganized thoughts		Weight concerns
	Concerns about gender		Feeling helpless		Other addictive behaviors

Medical conditions (illnesses, surgeries, hospitalizations): _____

Medications (current and past):_____

Cultural and/ or ethnic observations or considerations:_____

Spiritual and/or religious considerations:_____

Please write down any other information that would be helpful for me to know about the problems, situation, or what you would like to accomplish in treatment?

_____

_____