Date of Assessment:_____

Jaimie Baecker, LMHC
Spero Counseling Services, LLC.

*****FOR CONFIDENTIAL USE ONLY*****

CLIENT NAME:_____ DATE of BIRTH:_____

MAILING ADDRESS:_____

PHONE NUMBER WHERE YOU PREFER TO BE REACHED *and* IT'S OKAY TO LEAVE A MESSAGE: _____ (PLEASE INITIAL) _____

ALTERNATIVE CONTACT NUMBER (HOME/WORK):_____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME:_____ NUMBER:_____

OCCUPATION: _____ EMPLOYER:_____

RELATIONSHIP STATUS: single living together married separated divorced HOW LONG? ____

SPOUSE/PARTNER NAME: _____

SPOUSE/PARTNER ADDRESS: _____

IF MINOR, PARENT'S NAMES: _____

CHILDREN: (indicate step-children *)

Name	Age	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH CONDITIONS: list any medical conditions for which you are currently receiving treatment or need to receive treatment:_____

_____

Physician's name:_____

List any medications you are taking and for what purpose: _____

_____

Date of Assessment:_____

How much alcohol do you consume per week? _____

What drugs have you used for other than medical purposes? (Include dates and quantity)

_____

Please state in your own words why you are seeking help at this time and what you would like to achieve with counseling: _____

_____

_____

Please circle any of the issues or symptoms below that have been a concern to you over the past 30 days (Indicate Top 3 with *):

□ Addiction □ Anger/hate/rage □ Anxiety/worry/fear □ Apathy □ Argumentative □ Bitterness □ Blames others for behavior □ Boundaries □ Bullies/Intimidates others □ Burnout/stress □ Change of lifestyle □ Child abuse □ Children/Parenting □ Chronic Pain/Illness □ Codependency □ Communication □ Concentration □ Confusion □ Cruelty to animals □ Deceitful □ Defiant Behavior □ Deliberately Annoys others □ Depression □ Destruction of property □ Divorce □ Domestic violence (Perpetrator / Victim)	□ Eating Disorder □ Extra Marital Affair □ Family Relationships (father/mother/in laws) □ Finances □ Fire-setting □ Forgiveness □ Frustrations □ Gang involvement □ Grief/Loss □ Guilt □ Hallucinations (auditory/visual) □ Helplessness □ Hopelessness □ Hyperactivity □ Intimacy □ Irritability □ Impulse Control □ Language/Speech Impairment □ Loneliness □ Marriage □ Manipulative □ Moodiness □ Muscle Tension □ Panic Attacks □ Physical Abuse (victim)	□ Poor time management □ Poor organizational skills □ Punches/kicks walls/slams doors, etc □ Rape □ Rejection □ Religion/Faith □ Restlessness/On-Edge □ Runaway □ Self-esteem (low) □ Self-esteem (high) □ Self-injurious behaviors □ Separation □ Sex/Impotency □ Sexual Abuse (perpetrator / victim) □ Shoplifting/Stealing □ Sleep Disturbance/ nightmares/insomnia □ Suicide □ Tearfulness □ Trust Issues □ Verbal Conflict □ Violence (weapon: Y / N) □ Withdrawl/Isolation

Date of Assessment:_____

FAMILY OF ORIGIN:

Name	Still Living?	Where?

MOTHER: _____

FATHER: _____

SIBLINGS (please list names and ages in birth order and include yourself):

_____

_____

_____

Who else had a key role in your upbringing? (Indicate when in your life)_____

_____

Does anyone in your family have a history of mental health disorders? Y N
(Relation/Diagnosis)_____

_____

Have you participated in mental health counseling or received psychiatric care previously? Y N

If yes, please list when and where you received those services. _____

List any previous Mental Health Diagnoses:
_____ date diagnosed:_____ By Whom:_____

_____ date diagnosed:_____ By Whom:_____

TRAUMA HISTORY: Have you experienced a traumatic event in your lifetime? Y N

If yes, please explain: _____

_____

MILITARY EXPERIENCE:
Military Branch_____ Dates Served _____Rank _____

Type of Discharge (explain anything other than honorable): _____

_____

Were you disciplined while in the service? Y N Explain_____

_____

Please list any combat experience: _____