Into The Light
201 NW 4th St. Suite 105
Evansville, Indiana 47708
812/454-1564
Initial Assessment

1. PERSONAL INFORMATION

Name: ____ Address:____

City, State, Zip_____________________________ Cell Phone ______________ Social Security #_________________

Sex M/F/Other _________DOB________ Age________ Do you Currently Have Health Insurance Y/N_______________

Name of Health Insurance _______________ Name of Person Carrying Insurance _____________________________

DOB for Person Carrying Insurance_________ Emergency Contact Name and Number ________________________

Marital Status ____________ Name of Spouse or Partner if Applicable ______________________________________

Name and Ages of Children if Applicable ____

Place of Employment ______________________________ Occupation ______________________________________

2. ONSET, DURATION, COURSE OF SYMPTOMS

Why are you Seeking Treatment? What Current Symptoms are you Having That are Bothersome to you?
____
____

How Long ago did This Start?_______________How Long it Lasts/Frequency?________________________________

What is it Like? ____

3. CLIENT PSYCHIATRIC HISTORY

Have you Ever Been in Couseling/Therapy Before? Y/N _____ Type of Counseling/Therapy___________________

Name and City of Past Counselor/Therapist _____________________ Years/Months in Treatment_______________

Have you Ever Been Suicidal in the Past? Y/N_______ Are you Currently Thinking of Self-harm? Y/N ________

Do you Have a Current Plan to Harm Yourself? Y/N ___Do you have an Intent/Ability to Carry out a Plan? Y/N____

Have you Ever Been Homicidal in the Past? Y/N_______ Are you Currently Thinking of Harming Others? Y/N_____

Do you Have a Current Plan to Harm Others? Y/N _____

Previous Psychiatric Diagnoses Such as Depression, Anxiety, etc.:

Previous Medications and Dosage:

4. FAMILY PSYCHIATRIC HISTORY

List any Psychiatric Diagnosis/Visits/Counseling/Suicide Attempts by Family Members

Substance Use:

Suicide:

5. MEDICAL HISTORY	6. TRAUMA HISTORY
Explain in Detail Surgeries/Hospitalizations/Major Illnesses: General Health: Head Injury: Car Wrecks: Falls or Frequently Losing Balance: Current Medications and Dosage: Alcohol/Drug Use/Type/Frequency: Is Your Drug/Alcohol use Problematic?	*Circle Any That Apply* Prebirth Trauma Generational Trauma Birth Trauma Death of Parents as a Child Emotional Abuse Physical Abuse Sexual Abuse Neglect Lack of Food or Shelter Bullying in School Witnessed Domestic Violence Witnessed Violence Didn't Feel Safe or Loved Domestic Violence Rape Witnessed Violence Death of a Child Death of Spouse or Partner Traumatic Medical Interventions or Procedures Other ______________________________________

7. PERSONAL HISTORY
Place of Birth: **As a Child:** (Family Structure, Parents' Occupations, Relationship with Parents, Siblings, Friends, Abuse, School, Activities, Sex, Getting in Trouble at School or Home, Relationship With Family)

As an Adult: (Work, Finances, Education, Relationships, Sex Life, Family, Goals for Future, Trends in Functioning)

Past or Current Legal History:

Are you Currently Involved in a Lawsuit?

Are you Currently Working With an Attorney?

Personal Goals in Therapy:

1.

2.

3.