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? _____

PLEASE CIRCLE ANY CURRENT SYMPTOMS/EXPERIENCES IN THE FOLLOWING AREAS:

AREA 1
Low Mood for >2 Weeks
Sleep Change
Interest
Guilt/Worthlessness
Energy Change
Concentration
Appetite/Weight ▲
Psychomotor Slowing
Suicide:
Hopelessness/Plan/Access

AREA 2
Grandiose
Increased Activity
Goal-directed/High Risk
Decreased Judgment
Distractible
Irritability
Need Less Sleep
Elevated Mood
Speedy Talking
Speedy Thoughts

AREA 3
Hallucinations/Illusions
Delusions
Self-reference:
People Watching You
Talking About You
Messages From Media
Thought Blocking/Insertion
Disorganization:
Speech/Behavior

AREA 4
Trembling
Palpitations
Nausea/Chills
Choking/Chest Pain
Sweating
Fear:
Dying/Going Crazy
Anticipatory Anxiety
Avoidance
Agoraphobia

AREA 5
Excess Worry
Restless/Edgy
Easily Fatigued
Muscle Tension
Decreased Sleep
Decreased Concentration

AREA 6
Intrusive/persistent thoughts
Recognized as excessive/irrational
Repetitive behaviors:
Washing/Cleaning
Counting/Checking
Organizing/Praying

AREA 7
Experienced/Witness Event
Persistent Re-experiencing
Dreams/Flashbacks
Avoidance Behavior
Hyper-arousal:
Vigilance/Startle Response

AREA 8
Performance Situations:
Fear of Embarrassment
Fear of Humiliation
Criticism

AREA 9
Fear Abandonment/Rejection
Unstable Relationships
Chronic Emptiness
Decreased Self Esteem
Intense Anger/Outbursts
Self-damaging Behavior
Labile Mood and Impulsivity

AREA 10
Forensic History:
Arrests/Imprisonment
Aggressiveness/Violence
Lack of Empathy/Remorse
Lack of Concern for Safety:
Self or Others
Childhood Conduct Disorder

AREA 11
Heights/Crowds/Animals

AREA 12	**AREA 13**
Excess Concern With Appearance or Certain Part of Body Avoidance Behavior	Binging/Purging/Restriction/Amenorrhea Perception of Body Image or Weight

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

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?

6. TRAUMA HISTORY

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.