# **Therapy Assessment**

## **Clinician Information**

Name:
Title/Position:
License Number:
Contact Information:
Date of Assessment:
Time of Assessment:
Client Information
Name:
Age:
Gender:
Date of Birth:
Client ID:
Referring Physician/Agency (if applicable):
Presenting Problem
Chief Complaint:
Duration of Symptoms:
Previous Treatment Attempts:
Current Medications:

# **Mental Health History**

Past Psychiatric Diagnoses:
Past Hospitalizations:
Family History of Mental Health Issues:
Substance Use History:
Assessment of Symptoms
Mood and Affect:
Anxiety Levels:
Depressive Symptoms:
Thought Process (e.g., logical, coherent):
Suicidal Ideation: ☐ Yes ☐ No
Details:
Homicidal Ideation:   Yes   No
Details:

# **Cognitive Functioning**

Memory (Short-term/Long-term):	
Concentration/Attention:	
Executive Functioning (planning, organizing):	
Orientation (time, place, person):	
Social and Occupational Functioning	
Relationships with Family/Friends:	
Performance at Work/School:	
Leisure Activities/Interests:	
Social Support System:	
Goals for Therapy	
Short-term Goals:	
Long-term Goals:	
Client's Motivation Level:	

#### **Risk Assessment**

Risk to Self:
Risk to Others:
Vulnerability to Exploitation:
Treatment Plan
Therapeutic Modalities (CBT, DBT, etc.):
Frequency of Sessions:
Medication Consultation/Referral:
Additional Referrals (Psychiatry, Group Therapy, etc.):

## **Clinician's Observations and Recommendations**

Observations:	
Initial Impressions:	
Recommendations:	
Consent for Treatment	
l, [	], hereby consent to engage in the
therapy process as outlined above and understand th	e nature of treatment proposed.
Client's Signature:	_ Date:
Clinician's Signature:	Date: