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

I, [_____], hereby consent to engage in the therapy process as outlined above and understand the nature of treatment proposed.

Client's Signature: _____ **Date:** _____

Clinician's Signature: _____ **Date:** _____