

# Therapy Assessment

Client information	
Name:	Date of birth:
Sex:	Client ID:
Referring practitioner (if applicable):	
Practitioner information	
Name:	Title/position:
License number:	Email contact:
Date of assessment:	Time of assessment:
Presenting problem(s)	
Chief complaint:	Duration of symptoms:
Previous treatment (if any):	Current medications:
Mental health history	
Past psychiatric diagnoses:	Past hospitalizations:
Family history of mental health issues:	Substance use history:

<b>Assessment of symptoms</b>	
<b>Current affect:</b>	
<b>Anxiety scale 1 - 10 (1 = no symptoms 10 = extreme symptoms):</b>	
<b>Depression scale 1 - 10 (1 = no symptoms 10 = extreme symptoms):</b>	
<b>Additional notes:</b>	
<b>Risk assessment</b>	
<b>Risk to self:</b>	<b>Risk to others:</b>
<b>Suicidal ideation:</b> Yes      No	
<b>Additional notes:</b>	
<b>Therapeutic goals</b>	
<b>Short-term goals:</b>	<b>Long-term goals:</b>

<b>Observations and recommendations</b>
<b>Observations:</b>
<b>Recommendations:</b>
<b>Practitioner's notes</b>