Name_____ Date:_____

To help us better understand your needs and support you more effectively, we'd like you to complete a brief self-assessment. There are no right or wrong answers; please don't feel pressured to answer any question. We encourage you to be as open as you feel comfortable. Your responses will help guide our conversations and ensure we focus on what matters most to you.

This assessment explores in different areas of your life—physical, spiritual, relational, social, and vocational health. Please complete this self-assessment, prior to your initial appointment, keeping answers brief.

During your initial appointment, your clinician will ask you specific questions about your emotional health.

Instructions:

1. Take your time—most people complete the assessment in about 20 minutes.
2. Please answer each question based on how you've been feeling or functioning in the past year.
3. If you're unsure about an answer, just do your best; you can always skip or discuss it with your clinician later.

If you have any questions or need help as you go, please contact our office.

Physical Health

Do you have any current or past medical condition(s) or surgical procedures (such as: diabetes, hypertension, thyroid issues, or chronic pain)? [ ] Yes [ ] No [ ] Unknown

If yes, please provide details and include timeframe(s):

If yes, describe how these have impacted your mental health:

Are you suffering from any serious bodily injury? [ ] Yes [ ] No [ ] Unknown

If yes, please provide details and include timeframe(s):

If yes, describe the impact to your mental health:

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Have you ever experienced any physical accident or natural disaster that impacted your mental health?
[ ] Yes [ ] No [ ] Unknown
If yes, please provide details and include timeframe(s):

If yes, describe the impact to your mental health:

Describe any issues you are currently having with sleep, appetite, energy levels, weight, lifestyle, etc:

Please list all current medications and supplements (vitamins/minerals) you are currently taking (If you need more space, please indicate this to your clinician at the time of the initial appointment):

Medication/Supplement	Dosage	Prescribed By:	Why Prescribed?	Current Response? (Good/Fair/Poor)

List any other current mental health treatment:

Name	Location	When? *(month/year)*	For how long?

Doctor/NP/PA: _____

Clinician: _____

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Psychiatric Hospitalization (any residential or day treatment programs, including any alcohol/drug treatment programs **in the past 2 years**):

Where?	When? *(month/year)*	Length of Stay	Type of Treatment	Diagnosis

Spiritual Health

Do you practice your spirituality? [ ] Yes [ ] No [ ] Unknown

Do you have a specific faith tradition you align with? [ ] Yes [ ] No [ ] Unknown
If yes, what faith tradition?

Do you attend a local church, temple, synagogue, or mosque? [ ] Yes [ ] No
If yes, would you like to share where you attend?

If yes, how often are you attending?
[ ] 2-3 times per week
[ ] Weekly
[ ] 2 times per month
[ ] Never
[ ] Monthly
[ ] As needed
[ ] Holidays & Special Occasions

If yes, are you attending online or in-person?
[ ] Online [ ] In-Person [ ] Hybrid (online and in-person)

Do you believe your spirituality impacts your emotional health?
[ ] Yes [ ] No [ ] Unknown

Do you wish for your spirituality to be integrated into your care?
[ ] Yes [ ] No [ ] Unknown

Any additional comments or experiences regarding your spirituality you would like to share:

Cultural/Heritage

What is your race? (choose one)
[ ] American Indian or Alaskan Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] White or Caucasian
[ ] Other Please describe: _____

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What is your ethnicity? (choose one)
[ ] Hispanic or Latino
[ ] Not Hispanic or Latino

Provide short answers for the next few questions (share as you feel led):

Please share any information about your cultural background, ethnic heritage or family values:

Do your cultural background, ethnic heritage or family values affect your mental health?

What aspect of your culture background, ethnic heritage or family values is most important to your well-being?

Have you ever experienced racism, discrimination, or marginalization that affects your mental health?

Is there anything about your language, customs, or traditions that you would like respected during treatment?

Family Health

Who make up your current living situation (check all that apply):
[ ] Parent(s)
[ ] Roommate(s)
[ ] Spouse/Partner
[ ] My children
[ ] My spouse's/partner's children
[ ] My grandchildren
[ ] Other (please describe):_____

In your current family relationships, please answer the following true/false questions:

We talk to each other about things that matter to us.
[ ] True [ ] False

It feels risky to disagree in our family.
[ ] True [ ] False

It feels happy and content in our family.
[ ] True [ ] False

My family members are kind and respectful to each other most of the time.
[ ] True [ ] False

We are good at working through difficult situations.
[ ] True [ ] False

When one of us is upset, we look after each other.
[ ] True [ ] False

There is or has been violence within my family.
[ ] True [ ] False

My current family relationships impair my quality of life.
[ ] True [ ] False

The family I grew up in continues to impair the quality of my life.
[ ] True [ ] False

Relational Health

Would you like to share information about your sexual orientation or gender identification?

My current relationship status is:

[ ] Single	[ ] Separated
[ ] In a relationship	[ ] Divorced
[ ] Engaged	[ ] Widowed
[ ] Married	

Are you satisfied in your current marital/committed partner relationship?
[ ] Yes [ ] No [ ] N/A

If no, are you seeking relationship counseling as well?
[ ] Yes [ ] No

Briefly describe your most treasured relationship(s):

Social Health

Are you satisfied with your social life?
[ ] Yes [ ] No
If no, please answer:

Do you feel included and accepted by others?
[ ] Yes [ ] No

Do you feel lonely or left out?
[ ] Yes [ ] No

Do you have close friends you can count on?
[ ] Yes [ ] No

Is it hard for you to make new friends?
[ ] Yes [ ] No

Do you feel supported by the people around you?
[ ] Yes [ ] No

Have you ever experienced bullying, teasing, or being excluded?
[ ] Yes [ ] No

Do you feel comfortable saying "no" when you need to?
[ ] Yes [ ] No

Do people respect your space and choices?
[ ] Yes [ ] No

Overall, how do you feel about your relationships?
[ ] Positive [ ] Stressful [ ] Distant [ ] Oppositional [ ] Other? Please describe:

Who do you trust to contact when you have problems?

Do you struggle with (check any that apply):
[ ] Conflict with peers/friends
[ ] Problems with social interaction
[ ] Feeling withdrawn
[ ] Difficulty making/keeping friends
[ ] Feeling no/limited support
[ ] No relational issues

Recreation

What are your hobbies and interests? (I.E. woodworking, fashion)

What do you do in your leisure time?

What do you believe are your personal strengths, talents and abilities? (I.E. resilient, gifted artist, great with people)

Vocational Health

What is the highest education level you have accomplished (check one):
[ ] High School Graduate/GED
[ ] Vocational/Technical Degree or Certifications
[ ] Associate Degree
[ ] Bachelor's Degree
[ ] Master's Degree
[ ] Doctoral Degree
What field of work are you in?

Are you currently employed?
[ ] Yes [ ] No

Are you financially distressed?
[ ] Yes [ ] No

Do you feel you are underemployed for the skills and talents you possess?
[ ] Yes [ ] No

Are you satisfied/content with the work you do?
[ ] Yes [ ] No

Is your current vocation causing you any significant health problems?
[ ] Yes [ ] No

Thank you for completing this assessment. We appreciate your time and effort. We look forward to seeing you in our office.

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