Associated Counseling Group

♦ 748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
♦ 402-941-7016 ♦

Pre-Treatment Assessment

Client Name:_____ _____ Date:_____

Date of Birth:_____ _____ Age:_____Race_____

Primary Client's SS#:_____Medicaid #_____ _____ _____

Family's Address:_____ _____

City/ State/ Zip:_____ _____

Home Phone#:_____Work Phone#: _____Cell #_____

Email: _____

Name of legal guardian (if applicable)_____

Guardianship status, address and phone (if different from above)_____

_____

Individuals present at Interview: _____ _____

Insurance information _____Policy #_____

Have you been informed of the 24 hour rescheduling/cancellation policy? ☐ Yes ☐ No

Did you receive a copy of the Notice of Privacy (generally on back of packet)? ☐ Yes ☐ No

Employer:_____

Emergency Contact:_ _____ _____

I What is the Presenting Problem(s) that bring you to seek counseling -- Describe problems, pressures, or concerns (etc.) (**Document** date **presenting problem(s)** *started*, the frequency, duration, and intensity):

_____ _____

_____

Client's inner Strengths and current social condition? _ _____ _____

_____

Client's talents/skills/abilities/preferences//achievements _____

_____

A. Are there any Behavioral Concerns? (truancy, oppositional behaviors, conduct issues, legal and school problems, etc.):
--Indicate place of most frequent problems

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

B. Emotional concerns (withdrawn, sullen, mood issues, etc.)
--Indicates place of most frequent problems

_____

_____

_____

C. Individual (difficult establishing interpersonal relationships, dating issues, substance abuse issues, etc.) **or** Marital Concerns (divorces, infidelity, separations, multiple marriages, substance abuse issues, etc.)

_____

_____

_____

_____

Personal Status:

Married_____ Single_____ Divorced_____Separated_____ Widowed_____
If married name of spouse___ _____Age_____
Children Name_____Ages_____Race_____
Children Name_____Ages_____Race_____
Children Name_____Ages_____Race_____
Children Name_____Ages_____Race_____
Children Name_____Ages_____Race_____
Children Name_____Ages_____Race_____
How are your relationship(s)_____ _____

As a child/adolescent did you experience any of the following?

Attempted Suicide_____	Sexual Molestation_____
Suicidal Thoughts_____	Running away_____
Deliberate Self Injury_____	Adoption _____
Foster Care_____	Feeling Abandoned_____
Wanted by Parents_____	Sibling Rivalry_____
Hospitalization_____	Unconsciousness_____

II. Mental Health History

A. Individual Psychiatric / Psychological History:

List any prior occasions you may have attended counseling, or treatment, please include where you were seen, who your therapist was, who attended sessions and what the concern(s) was(were):

_____

_____

_____

_____

What previous treatment interventions were used in past treatment_____
Was past treatment helpful? yes no uncertain

Please check any of the following issues that you or anyone in your family may have or have had (if not you please list your relationship to individual):

_____

- Learning Disabilities _____
- Behavior Issues _____
- Mental Issues _____
- Anxiety _____
- Family Drug/Alcohol use_____

  - ClientDrugs/Alcohol use _____

  If client is over the age of 12 complete the following
  First use of Nicotine___ usual amount consumed_____usual frequency of use____
  Last use____
  First use of Caffeine___ usual amount consumed_____usual frequency of use____
  Last use____
  First use of Alcohol___ usual amount consumed_____usual frequency of use____
  Last use____
  First use of Illicit Drugs___ usual amount consumed_____usual frequency of use____
  Last use____(use back of form to list drugs and use pattern and history information)

- Suicide/Homicide _____
- Physical Abuse _____
- Sexual Abuse _____
- Self Esteem Issues _____
- Other Issues Not Listed _____

Are there any social or emotional concerns for you or your family in your history?

_____

_____

_____

Please indicate most recent lab testing completed, results and recommendations, include the Reason for testing and ordering physican. _____

_____

_____

Who are the people that you count on to help you when you need help in a given situation?

_____

Please list
Hobbies/Preferred Activities:_____
_____
_____
What is your current living situation?
_____
_____

Sexual Activity:

_____
_____
_____
_____

Legal History: (use back for more space if needed)

List crimes committed against you _____
List past crimes charged with_____
List current legal issues_____
_____

Educational History:

Please list highest level of education and last school attended along with any degrees received**:**
_____
_____

What is your current spiritual belief?_____
What is it you do for a living?_____ full or part time
List any volunteer activates_____

III. Medical History:

□ Hospitalizations (Where? When? MD? Meds? Reasons?)

_____
_____
_____
_____

Have you ever taken prescribed medications for any illness? if yes please list

_____
_____
_____
_____

□ Chronic Illness (allergies, pain, diabetes, disabilities, Meds?)

_____
_____
_____
_____

□ Developmental history ((for woman include menstrual history, pregnancies) developmental milestones met, births, etc.)

_____
_____
_____
_____

Date of last visit to the doctor_____ Doctor's Name_____
Address of Primary Care Physician: _____

Phone of Primary Care Physician:_____

Current Medical concerns/treatment_____

Current Medications:	Purpose:	Dosage:	Prescribed By:	First Prescribed:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date of the most recent refill of each medication listed:

_____ _____ _____ _____

Risk Factors:
Are there any risk situations that put you in danger at this time?

_____

IV. What You Want From Therapy, list what you would like to accomplish through the therapeutic process:

1) Goal/Objective:

_____
_____
_____

2) Goal/Objective:

_____
_____
_____

3) Goal/Objective:

_____
_____
_____

_____

Therapist **Date**