Wyandot Counseling Associates, LLC
CLIENT SELF-ASSESSMENT

Name _____ Date _____

What is happening in your life which resulted in this appointment?

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What would you like to see accomplished in therapy? _____

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CHIEF COMPLAINTS (CHECK ALL THAT APPLY TO YOU)

____ Depression
____ Low Energy
____ Low Self-Esteem
____ Poor Concentration
____ Hopelessness
____ Worthlessness
____ Guilt
____ Sleep Disturbance (more/less)
____ Appetite Disturbance (more/less)
____ Thoughts of hurting yourself
____ Thoughts of hurting someone
____ Isolation/Social Withdrawal
____ Sadness/Loss
____ Stress
____ Anxiety/Panic
____ Heart Pounding/Racing
____ Chest Pain
____ Trembling/Shaking
____ Sweating
____ Chills/Hot Flashes
____ Tingling/Numbness
____ Fear of Dying
____ Fear of Going Crazy
____ Nausea
____ Phobias
____ Obsessions/Compulsive Behaviors
____ Thoughts Racing
____ Can't hold onto an Idea
____ Easily Agitated
____ Excessive Behaviors (Spending/Gambling)
____ Delusions/Hallucinations
____ Not thinking clearly/Confusion
____ Feeling that you are not real
____ Feeling that things around you are not real
____ Lose track of Time
____ Unpleasant thoughts won't go away
____ Anger/Frustration
____ Defying Rules
____ Blames others
____ Excessive use of prescription medications
____ Excessive use of drugs and/or alcohol
____ Blackouts
____ Physical Abuse Issues
____ Sexual Abuse Issues
____ Spousal Abuse Issues
____ Other Problems/Symptoms

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