

Door of Hope Counseling
1201 North Watson Road Suite 299
Arlington, Texas 76006

SELF ASSESSMENT

What is happening in your life that has resulted in this appointment? _____

What do you hope to accomplish in therapy? _____

Check all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Feeling that things around you are not real |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Lose track of time |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger/frustration |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Easily agitated/annoyed |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Defies rules |
| <input type="checkbox"/> Sleep disturbance (more/less) | <input type="checkbox"/> Blames others |
| <input type="checkbox"/> Appetite disturbance (more/less) | <input type="checkbox"/> Argues |
| <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> Excessive use of drugs and/or alcohol |
| <input type="checkbox"/> Thoughts of hurting someone | <input type="checkbox"/> Excessive use of prescription medications |
| <input type="checkbox"/> Isolation/social withdrawal | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Sadness/loss | <input type="checkbox"/> Physical abuse issues |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexual abuse issues |
| <input type="checkbox"/> Anxiety/panic | <input type="checkbox"/> Spousal abuse issues |
| <input type="checkbox"/> Heart pounding/racing | <input type="checkbox"/> Other problems/symptoms |
| <input type="checkbox"/> Excessive behaviors (spending, gambling) | <input type="checkbox"/> Delusions/hallucinations |
| <input type="checkbox"/> Not thinking clearly | _____ |
| <input type="checkbox"/> Chest pain | _____ |
| <input type="checkbox"/> Trembling/shaking | _____ |
| <input type="checkbox"/> Sweating | _____ |
| <input type="checkbox"/> Chills/hot flashes | _____ |
| <input type="checkbox"/> Tingling/numbness | _____ |
| <input type="checkbox"/> Fear of dying | _____ |
| <input type="checkbox"/> Fear of going crazy | _____ |
| <input type="checkbox"/> Nausea | _____ |
| <input type="checkbox"/> Phobias | _____ |
| <input type="checkbox"/> Obsessions/compulsive behaviors | _____ |
| <input type="checkbox"/> Thoughts racing | _____ |
| <input type="checkbox"/> Can't hold onto an idea | _____ |
| <input type="checkbox"/> Easily agitated | _____ |