Door of Hope Counseling

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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:

____Depression
____Feeling that you are not real
____Low Energy
____Feeling that things around you are not real
____Low self-esteem
____Lose track of time
____Poor concentration
____Unpleasant thoughts won't go away
____Hopelessness
____Anger/frustration
____Worthlessness
____Easily agitated/annoyed
____Guilt
____Defies rules
____Sleep disturbance (more/less)
____Blames others
____Appetite disturbance (more/less)
____Argues
____Thoughts of hurting yourself
____Excessive use of drugs and/or alcohol
____Thoughts of hurting someone
____Excessive use of prescription medications
____Isolation/social withdrawal
____Blackouts
____Sadness/loss
____Physical abuse issues
____Stress
____Sexual abuse issues

____Anxiety/panic
____Spousal abuse issues
____Heart pounding/racing
____Other problems/symptoms
____Excessive behaviors (spending, gambling)
____Delusions/hallucinations
____Not thinking clearly
____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
_____

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