Initial Assessment Checklist

Client Name: **Date:**

CLIENT INFORMATION

- Full Name ○
- Date of Birth ○
- Gender ○
- Contact Information ○
- Emergency Contact ○

PRESENTING ISSUES

- Primary Complaint ○
- Duration of Symptoms ○
- Severity of Symptoms ○
- Impact on Daily Life ○

MEDICAL HISTORY

- Current Medications ○
- Allergies ○
- Past Medical History ○
- Family Medical History ○

SUBSTANCE USE HISTORY

- Types of Substances Used ○
- Frequency and Quantity ○
- Duration of Use ○
- Previous Treatment for Substance Use ○

Initial Assessment Continued

MENTAL HEALTH HISTORY

Previous Mental Health Diagnoses ○

History of Therapy or Counseling ○

Current Mental Health Symptoms ○

SOCIAL HISTORY

Living Situation ○

Employment Status ○

Support System ○

Legal Issues ○

RISK ASSESSMENT

□ Suicidal Ideation ○

□ Homicidal Ideation ○

□ Self-Harm Behavior ○

□ Risk to Others ○

ASSESSMENT TOOLS

Additional Assessment Tool Completed _____ ○

Additional Assessment Tool Completed _____ ○

Additional Assessment Tool Completed _____ ○

Client Signature: _____

Clinician Signature: _____