Life Transitions Counseling, PLLC
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Initial Assessment Questionnaire

Please feel free to attach answers if more space is needed.

Name: _____

Date of Birth: _____

Today's date: _____

Address: _____

Email address: _____

Home phone (____)_____

Work phone (____)_____

Cell phone (____)_____

Best number to reach you at: _____

May we leave a message at this number and/or text, email you? _____

Employer: _____

Position/Title: _____

Length of employment: _____

Are you satisfied with your work? If not, why? _____
_____

Highest level of education completed: _____

Who do you live with, if anyone? _____

Marital Status: _____

If not married, are you in a committed relationship: _____

Length of time in current relationship: _____

Sexual Orientation: _____

Do you have children, and if so what are their ages? _____

How would you describe the interactions and relationships with each of your family members including family of origin? _____
_____

Where were you raised? _____

Do you have close friends? _____

Do you have relationships with friends from your past? _____

What is your history with your co-workers? _____

How do you like to spend your free time? _____

Do you have any current or historic use of drugs? _____
Types of drugs used: _____
Frequency of drug use: _____

Any prescription drugs taken-please list all prescription medications currently taken: _____
_____

Alcohol use. How often do you have an alcoholic drink? _____
How many drinks per week do you consume? _____
Have you ever had blackouts after drinking? _____

Have you ever been diagnosed with a substance abuse problem? _____

Have you ever seen a therapist? _____

If so, who did you see, for what issues and for how long did the therapy last? _____
_____

Did you consider the therapy successful? _____

Have you ever been hospitalized for any substance abuse or mental health issues? _____

Have you ever been diagnosed with any mental health problems? _____

Have you ever felt suicidal? _____

Have you ever attempted to commit suicide? _____

What are your biggest stressors? _____

Have you ever had a panic attack? _____

Would you describe yourself as an angry person? _____

Do you often cry? _____

Do you know why you cry? _____

What is the quality of duration of your sleep? _____

How is your appetite? _____

Do you have problems with food- binge eating, any history of anorexia? _____

Do you have a primary physician? _____

Name and phone number: _____

What was the date of your last visit? _____

Do you have any health issues? _____

Do you exercise? _____

How often, what do you do? _____

Are you a spiritual person? _____

Are you a religious person? _____

What is your religion? _____

Do you attend a place of worship regularly? _____

Why have you decided to come in to speak with me today? _____

What would you like to be different in your life? _____