NHC ASSESSMENT and HISTORY INFORMATION
This information will help you and your therapist begin to clarify your therapy goals.

Patient Name: ___________________________________  Date: _________________________

☐ Yes  ☐ No Have you ever been treated by a psychiatrist?

☐ Yes  ☐ No Have you ever been hospitalized for mental or chemical dependency treatment?

☐ Yes  ☐ No Have you seen another therapist in the past 24 months?

If yes, who did you see? ______________________________________________________

☐ Yes  ☐ No Have you ever attempted suicide?

If yes, when? _____________________________________________________________________

Briefly describe your reasons for seeking counseling services: ______________________________

__________________________________________________________

What kind of things have you tried so far to handle this situation?: __________________________

__________________________________________________________

Please place a number that best corresponds to the issue listed below: (rate those that apply)

<table>
<thead>
<tr>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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___ Abuse – physical
___ Abuse – sexual
___ Abuse – emotional
___ Aggression, violence
___ Alcohol use
___ Anxiety, nervousness
___ Attention, distraction
___ Co-dependence
___ Confusion
___ Cruelty to animals
___ Crying, sadness
___ Decision-making, indecision
___ Delusions (false ideas)
___ Drug Use (prescribed)
___ Divorce, separation
___ Drug Use (illegal)
___ Eating problems
___ Financial
___ Grieving
___ Goals
___ Guilt
___ Heads
___ Impulsiveness
___ Judgment
___ Loss of control
___ Marital/Partner
___ Memory problems
___ Menstrual, PMS, menopause
___ Mood swings
___ Parenting
___ Obsession/compulsion
___ Panic/Anxiety attacks
___ Parenting
___ PTSD
___ School problems
___ Self-esteem
___ Sexual issues
___ Sleep problems
___ Stress
___ Suicidal thoughts
___ Tobacco use
___ Temper/low tolerance
___ Thought disorganization
___ Work problems

Other: ____________________________________________________________
In the past 36 months has there been a death of a family member or someone close to you?

☐ Yes ☐ No If Yes, who? ___________________________ When: ___________ Relationship: ___________

Prior to the 36 months, has there been a death of someone that was close to you?

☐ Yes ☐ No If Yes, who? ___________________________ When: ___________ Relationship: ___________

Please rate below on a scale of 1 though 10, 1 = not at all, and a 10 = very much so:

_____ I was very close and had a good relationship with my father.

_____ I was very close and had a good relationship with my mother.

_____ I was very close and had a good relationship with my siblings.

_____ I have several good friends.

_____ I often have nightmares.

_____ I enjoy spending time alone.

_____ I have a tendency of agreeing with other people to avoid confrontations.

_____ I don’t like being around other people, I want to be alone.

_____ I like myself.

_____ I have a healthy interest in sex.

_____ I sometimes am confused with my identity.

_____ I put the needs and wishes of others first before myself even if I am not comfortable with it.

_____ I think I am responsible for the way others feel and their behaviors

_____ I drink alcoholic beverages at least 3 times per week.

_____ I have a problem saying “no”

_____ Others can make me mad, frustrated, disappointed, or sad easily.

Fears or concerns of counseling: ____________________________________________________________

____________________________________________________________________________________

Goal or expectation of counseling: _______________________________________________________

____________________________________________________________________________________