NHC ASSESMENT 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)

NEVER		RARELY		SOMETIMES			OFTEN		ALWAYS
1	2	3	4	5	6	7	8	9	10

____Abuse – physical	____Abuse – sexual	____Abuse – emotional
____Abuse – neglect	____Aggression, violence	____Alcohol use
____Anger, hostility, irritable	____Anxiety, nervousness	____Attention, distraction
____Career concerns, goals, choices	____Co-dependence	____Confusion
____Compulsions	____Cruelty to animals	____Crying, sadness
____Custody of children	____Decision-making, indecision	____Delusions (false ideas)
____Depression	____Divorce, separation	____Drug Use (prescribed)
____Drug Use (illegal)	____Eating problems	____Financial
____Gambling	____Grieving	____Goals
____Guilt	____Headaches	____Impulsiveness
____Judgment	____Loss of control	____Marital/Partner
____Memory problems	____Menstrual, PMS, menopause	____Mood swings
____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: ____

____