Into the Light
Mental Health and Consulting Services, Inc.
201 NW 4th St. Suite 105
Evansville, IN 47708
812-454-1564
Laura Symon, MSW, LCSW, CSAT, SEP

Initial Assessment

1. PERSONAL INFORMATION

Name*: _____ Address*:_____

City*: _____ State*: _____ Zip*: _____ Email*: _____ Cell Phone*: _____

Social Security #*: _____ Sex*: ☐Male ☐Female ☐Other:_____ DOB*: _____

Do you currently have health insurance?* Y or N? Name of Health Insurance*: _____

Name of Person Carrying Insurance*: _____ DOB for Person Carrying Insurance*: _____

Emergency Contact Name*: _____ Emergency Contact Number*: _____

Marital Status: _____ Name of Spouse or Partner (if applicable): _____

Name and Ages of Children (if applicable): _____

Place of Employment: _____ Occupation: _____

2. ONSET, DURATION, AND COURSE OF SYMPTOMS

Why are you seeking treatment?* _____

What current symptoms are you having that are bothersome to you?* _____

_____

How long ago did this start?* _____ How long does it last, and how often?* _____

Describe what it feels like*: _____

_____

3. CLIENT PSYCHIATRIC HISTORY

Have you ever been in counseling/therapy before?* Y or N? Type of Counseling/Therapy: _____

Name & City of Past Counselor/Therapist: _____ Duration of Treatment:_____

Have you ever been suicidal in the past?* Y or N? Are you currently thinking of self-harm?* Y or N?

Do you have a current plan to harm yourself?* Y or N? Do you have an intent/ability to carry out a plan?* Y or N?

Have you ever been homicidal in the past?* Y or N? Are you currently thinking of harming others?* Y or N?

Do you have a current plan to harm others?* Y or N?

Previous psychiatric diagnoses such as depression, anxiety, etc.: _____

Previous medications and dosage: _____

4. FAMILY PSYCHIATRIC HISTORY

Does anyone in your family…

Have a psychiatric diagnosis? If so, please specify: _____

Currently attend therapy? If so, what for? _____

Have a history of completing suicide? If so, what is the relationship?_____

Have a history of attempting suicide? _____

Use substances? If so, what? _____

5. MEDICAL HISTORY *Explain in detail*	**6. TRAUMA HISTORY** *Circle all that apply*
Any surgeries/hospitalizations/major illnesses?:	Prebirth Trauma Generational Trauma Birth Trauma

Any head injuries?: Any car wrecks?: Do you frequently lose your balance or fall?: Current medications and dosage: Do you consume any drugs or alcohol? If so, what type, and how often?: Is your drug/alcohol use problematic?:	Death of a Parent as a Child Death of a Child Neglect Death of a Spouse or Partner Didn't Feel Safe or Loved Emotional Abuse Physical Abuse Sexual Abuse Bullying in School Lack of Food or Shelter Rape Witnessed Violence Domestic Violence Human Trafficking Traumatic Medical Interventions or Procedures Other: _____

7. PERSONAL HISTORY

Place of Birth: _____

As a child…

What was your family structure?: _____

What were your parents' occupations?: _____

How was your relationship with your family?*: _____

_____

How was your relationship with your friends?: _____

_____

How did you do in school? Did you participate in any activities?: _____

_____

Did you get in trouble at school or at home? If so, for what?: _____

As an adult…

How is your work?: _____

How are you doing financially?: _____

What is your highest degree of education?: _____

How are your relationships (both romantic and platonic)?*: _____

_____

How is your sex life?:_____

What is your family life like?: _____

What are your goals for the future?: _____

Past or current legal history*: _____

Are you currently involved in a lawsuit?*: _____

Are you currently working with an attorney? If so, whom?*: _____

Personal Goals in Therapy:

1.

2.

3.