Shaw Strannahan, MA, MFTI
Supervised by Julie Wells, M.S.
Licensed Marriage, Family Therapist
7545 Irvine Center Drive, Irvine, CA, 92618
410-924-2514

NEW CLIENT ASSESSMENT

Name(s): _____

Date: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Partner 1 DOB: _____ Cellular Phone: _____

Email Address: _____

Partner 2 DOB: _____ Cellular Phone: _____

Email Address: _____

Contact in Emergency Situation: _____

Telephone Number: _____ Relationship: _____

What concern/s brings you to counseling? _____

How did you find me? _____

(Psychology Today, Theravive, Google Search, Yelp, Referral, etc.)

_____

To be completed if Client is a Minor:

Parent/Guardian: _____

Contact Information:_____

If parents are divorced, who has legal custody? _____

MEDICAL HISTORY

Currently under a medical physician's care? YES/NO

If YES, please describe current medical condition/s: _____

_____

_____

Medications currently used: circle if NONE

Medication Dosage Dr. Prescribing Why Prescribed

_____ _____ _____ _____

_____ _____ _____ _____

Previous Counseling or Chemical Dependency Treatment/Services: NONE

Facility/Therapist's Name Date of Service Reason for Treatment Helpful (Y/N)

_____ _____ _____ _____

_____ _____ _____ _____

CHEMICAL DEPENDENCY ASSESSMENT

Have you ever attempted to reduce your alcohol intake? Y N

If yes, what was the outcome? _____

Do family members/friends ever complain about your drinking behaviors? Y N

Have you lost friends or alienated family members due to your drinking behaviors? Y N

Have you ever been reprimanded at work due to your drinking behavior? Y N

Do you ever use illegal drugs? Y N

If yes, please list/describe illegal drugs you currently use: _____

_____

Do you ever take prescription medication in a way that is not advised (more than prescribed or more than advised)? Y N

PERSONAL QUESTIONS

Do you currently feel suicidal (i.e., have thoughts of harming yourself in any way)? Y N

If yes, please describe your feelings/intent: _____

_____

Have you ever attempted suicide or to seriously harm yourself? Y N

If yes, please describe in detail: _____

_____

Do you currently have the intent to harm, seriously hurt, or kill another individual? Y N

If yes, please describe in detail: _____

_____

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? Y N If so, by whom?_____

Please describe what happened?

_____

_____

Do you feel safe in your current relationship? Y N

If no, please explain further: _____

_____

Have you ever been sexually abused? Y N

If yes, please explain further: _____

_____