Nashville CARES
Behavioral Health Services
Client Self-Assessment

Please take a few minutes to complete this self-assessment. Your responses are valuable in helping your therapist understand your experiences. Leave blank any questions you do not feel comfortable answering or would prefer to discuss with your therapist.

Name: _____ **Date of Birth:** _____

Preferred Name: _____ **Pronouns:** _____

Gender Identity: _____ **Sexual Orientation:** _____

Race: ☐ AA/Black ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Describe what issues led you seek therapy:

How long have you experienced these issues?

☐ <1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ >12 months

How difficult have these issues/problems made it for you to live your daily life?

☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Please check any symptoms that apply to you in the last year:

☐ Addiction
☐ Aggression
☐ Anger
☐ Anxious
☐ Chronic fatigue
☐ Decreased motivation
☐ Depressed mood
☐ Easily distracted
☐ Disturbing thoughts
☐ Feeling hopeless
☐ Feeling worthless
☐ Frequent crying
☐ Headaches
☐ Hearing unfamiliar voices
☐ Impulsive behaviors
☐ Irritability
☐ Isolating/withdrawing
☐ Loss of interest in hobbies
☐ Low energy
☐ Low self-esteem
☐ Memory issues
☐ Mood swings
☐ Nightmares
☐ Obsessive thoughts
☐ Panic attacks
☐ Perfectionism
☐ Phobias/fears
☐ Relationship conflict
☐ Restlessness
☐ Seeing things others cannot
☐ Self-harm
☐ Sexual difficulties
☐ Shame/guilt
☐ Sleep issues
☐ Suicidal thoughts
☐ Unexplained weight change
☐ Worrying a lot

What are your three biggest stressors?

1.
2.
3.

Client Self-Assessment (page 2)

Client Name: _____ Date: _____

Patient Health Questionnaire-4

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
Feeling nervous, anxious or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3

How would you rate your overall physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your physical health currently impacting your mental health? ☐ Yes ☐ No
If yes, please describe:

How would you rate your overall emotional health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever engaged in mental health treatment? ☐ Yes ☐ No

Have you ever engaged in substance use treatment? ☐ Yes ☐ No

Are you concerned about your use of alcohol or drugs? ☐ Yes ☐ No

Do you want to change your use of alcohol or drugs? ☐ Yes ☐ No

Has anyone in your life expressed concern about your use of alcohol or drugs? ☐ Yes ☐ No

How would you rate the quality of your sleep? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Check all that apply:

☐ Sleeping too much ☐ Sleeping too little ☐ Poor quality of sleep ☐ Nightmares

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Other: _____

Client Self-Assessment (page 3)

Client Name: _____ Date: _____

Please list any prescription medications, over-the-counter medications, & supplements you have taken regularly over the last 6 months:

Medication	Dosage	Date Last Taken	Prescriber	Prescribed/taken for

Are you currently working? ☐ Yes ☐ No

If yes, describe your work: _____

How satisfied are you with your current employment?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

Please list your interests, hobbies, community involvement:

What role does faith/spirituality play in your life?

How satisfied are you with your social supports?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

Are you currently in a romantic relationship? ☐ Yes ☐ No

If yes, how long have you been in this relationship? _____

How satisfied are you with your current romantic relationship?

☐ Very satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very unsatisfied

How often do you feel lonely?

☐ Never ☐ Hardly ever ☐ Sometimes ☐ Often ☐ Always

Client Self-Assessment (page 4)

Client Name: _____ Date: _____

Have you ever experienced any traumatic, life-altering, events?

Please list your three greatest personal strengths:

1.
2.
3.

What are your goals for therapy?

How confident are you that these goals can be accomplished?

☐ Extremely Hopeful ☐ Very Hopeful ☐ Somewhat Hopeful ☐ Not Hopeful

How confident are you in your ability to attend regularly scheduled therapy appointments and actively participate in your treatment?

☐ Extremely confident ☐ Very confident ☐ Somewhat confident ☐ Not confident

What barriers, if any, might get in the way of your ability to attend appointments?

Is there anything else you think is important to share with your therapist at this time?

_____ _____

Client Signature Date