FAMILY COUNSELING SERVICES INITIAL CASE ASSESSMENT

A. Client/Session Information

Client Name: Date:

Therapist: Time/Length of Session:

Modality:
Individual Family Couples Group Consultation

B. Identifying Information:

C. Presenting Problem(s):

D. Situational Stressors:

E. Assessment

Dress: Grooming:

Mood:
Euthymic Anxious Depressed Angry Euphoric

Affect:
Appropriate Intense Flat Inappropriate Labile

Mental Status:
Normal Unaware Memory problems Disoriented

Disorganized Vigilant Delusional Hallucinating

Other:

Suicide Risk: Violence Risk:

Sleep Quality: Appetite:

Treatment Compliance:
Full Partial Low/Non-Compliant

Response to Treatment:
Excellent As Expected Poor None

Strengths/Assets:

Medications/Medical Issues:

F. Topics Discussed:

Relationship(s):

Stressors:

Identity/Roles:

Work Problem(s):

Substance Use/Abuse:

Childhood/Family of Origin:

Sexual Problem(s):

Parenting:

Dreams/Nightmares/Sleep:

Behavioral Goals:

Depression:

Anxiety:

Anger:

Trauma:

Other:

G. Treatments & Interventions:

Insights:

CBT:

Homework:

Family/Relationship(s):

Communication:

Problem Solving:

Support:

Behavioral:

Couples:

Children:

Family:

EMDR:

Other:

H. Diagnosis:

DSM Diagnosis:

FAMILY COUNSELING SERVICES INITIAL CASE ASSESSMENT

K. Clinician Signature: Date:

This form was created using ChatGPT.