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:
Comments:

I. **Treatment Goals:**

1)
2)
3)
4)
5)
6)

J. **Notes:**

K. **Clinician Signature:** _______________________________ **Date:** _______________