972.824.2121

Linda W. McCune M.S., Licensed Professional Counselor

17770 Preston Rd. Suite D

Dallas, Texas 75252

Self-Assessment

Client: ________________ Date: ________________

What is happening in your life that resulted in this appointment? ______

____

What would you like to see accomplished in therapy? _________________

____

Chief Complaint (check all that apply):

__Depression
__Low energy
__Low self-esteem
__Poor concentration
__Hopelessness
__Guilt
__Sleep disturbance (more/less)
__Appetite disturbance (more/less)
__Thoughts of hurting self
__Thoughts of hurting someone
__Isolation/social withdrawal
__Sadness/loss
__Stress
__Anxiety/panic
__Heart pounding
__Chest pain
__Trembling/shaking
__Sweating
__Chills/hot flashes
__Tingling/numbness
__Fear of dying
__Fear of going crazy
__Nausea
__Feeling that you are not real
__Anger/frustration
__Lose track of time
__Unpleasant thoughts
__Easily agitated
__Defies rules
__Blames others
__Argues
__Excessive use of drugs/alcohol
__Excessive use of prescription meds
__Blackouts
__Physical abuse issues
__Sexual abuse issues
__Spousal abuse issues
__Feeling of "unreality"
__Obsessions/compulsive behaviors
__Thoughts racing
__Can't hold onto an idea
__Excessive behaviors (spending,etc.)
__Delusions
__Not thinking clearly/confusion
__Phobias

Previous outpatient therapy? ___Yes ___No Previous medications? ______________

Previous hospitalizations? ___Yes ___No If yes, when __________________________