Adolescent and Family Growth Center
Outpatient Services
New Client Self-Assessment

Please state briefly the three most important reasons why you are seeking therapy at this point:

1.

2.

3.

Please circle any of the following which describe how you are feeling currently:

Angry	Hopeless	Fatigued	Anxious	Panic
Energetic	Confused	Suicidal	Resentful	Cheerful
Ambitious	Dangerous	Unhappy	Hopeful	Outgoing
Distrustful	Inadequate	Indifferent	Jealous	Isolated
Lonely	Apathetic	Stressed	Fretful	Fearful
Irritable	Hurt	Numb	Depressed	Bereaved
Abused	Happy	Guilty	Violent	Ashamed
Worried				

Please circle any of the following which you have experienced in the last two weeks:

Puzzling or Bizarre Ideas	Relationship Stress	Loss of Control
Overeating	Drug Use	Alcohol Use

Unwelcome Thoughts	Poor Sex Drive	Loss of Faith
Loss of Meaning	Loss of Self-Respect	Work Stress
Loss of Appetite	Change in Sleeping Patterns	Family Conflict
Suicidal Thoughts	Homicidal Thoughts	General Medical Condition
Paranoid Thoughts	Memory Problems	Loss of Concentration
Death of a Loved One		

Please list the three most important things you would like to change as a result of participation in therapy:

1.

2.

3.

Thank you for your input! This information will be kept in your confidential client file and used by your therapist in the assessment and treatment planning process.