

Social Assessment

1. Describe how it was to grow up in your family. Be sure to include issues related to how discipline was handled, how feelings were dealt with, how losses were dealt with, any incidences of sexual abuse, economic status, and significant physical and/or emotional illnesses.
2. Has anyone in your family ever received treatment for psychiatric problems, alcoholism, other addictive behaviors, or other concerns?
3. If no one has ever received any such treatment, in your estimation is there anyone who should have received treatment?
4. Describe your current support system. Include personal relationships as well as support groups.
5. Describe your first sexual encounter.
6. Please describe your most recent or current sexual involvement. What conflicts and considerations exist due to this involvement?

Emotional Assessment

1. Have you ever experienced any of the following? If so, describe the situation.

___ Suicidal thoughts

___ Attempted Suicide

___ Depression

___ Severe anxiety

___ Explosive episodes

2. On a scale of 0 to 10 (with 0 being not at all and 10 being severe), how would you rate yourself currently?

___ Suicidal thoughts

___ Depression

___ Anxiety

___ Explosive episodes

Religious/Spiritual Assessment

1. Discuss your religious background and its effects positive and negative (if any) on your growth and development.

2. What are your beliefs about religion and/or spirituality currently?

3. Do you feel religion or spirituality is an important aspect of your life?

Medical History Self-Report

1. Height _____ Weight _____ Blood pressure _____
2. Have you gained/lost more than 10 lbs. in the past year? ____ Yes ____ No. If yes, how much?
3. What is your lowest and highest weight at your current height?
Lowest _____ Highest _____
4. Do you have a history of or currently have a significant medical condition?
____ Yes ____ No
If yes:
What condition(s)?

When was it diagnosed?

How was it treated?
5. Does your family have a history of:
____ Heart disease ____ Diabetes ____ Strokes ____ Thyroid disorders
____ Cancer ____ Obesity ____ Other significant illness (specify)
6. Do you follow a modified diet for health reasons? ____ Yes ____ No
If yes:
____ Diabetic ____ Low Sodium (salt) ____ Low cholesterol ____ Hypoglycemic
____ Low fat ____ Other
7. Are you satisfied with your eating patterns? ____ Yes ____ No
8. Do you currently (or have you ever routinely):
____ Binge ____ Vomit ____ Take laxatives ____ Take diet pills
____ Take water pills ____ Exercise excessively
9. Do you ever eat in secret? ____ Yes ____ No

Supplement

1. What else would you want to know if you were treating you?