Coastal Haven Counseling, LLC
220 Ronnie Ct Ste 2 Myrtle Beach, SC 29579
3100 Dick Pond Rd Ste D2 Myrtle Beach, SC 29588
3723-C Forestbrook Rd Myrtle Beach, SC 29588
(843) 945-0346

Initial Clinical Assessment

Client Name:_____Appointment Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Cell/Other Phone: _____ May we text or leave a message? Yes □ No □

Email: _____ May we leave a message? Yes □ No □

*Email or texting correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Marital Status: Never Married□ Married□ Separated□ Divorced□ Widowed□ Dom Partner□

Referred By (if any):_____

Reason you are seeking treatment: _____

_____

_____

Areas of your life it is affecting: _____

Household members, age and relationship:_____

_____

_____

Suicidal risk? [ ] Denies [ ] Ideas [ ] Plans [ ] Hx of attempts [ ] Hx in family

Homicidal risk? [ ] Denies [ ] Ideas [ ] Plans [ ] Hx of attempts [ ] Hx in family

Self-Mutilation? [ ] Denies [ ] Ideas [ ] Plans [ ] Hx of attempts [ ] Hx in family

Other risk behaviors: [ ]Denies [ ]Unprotected sex [ ]Gang affiliations [ ]Violence [ ]Fire setting

Have you had any issues with shoplifting? _____

_____

History: Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Yes □ No □ previous therapist/practitioner: _____

What was your diagnosis: _____

Did your previous treatment help? Yes □ No □ What did you learn from your previous treatment? _____

When and where was your previous treatment? Inpatient or outpatient? _____

_____

_____

General and Mental Health Information:

1. How would you rate your current physical health? Poor □ Satisfactory □ Good Very □

Please list any specific health problems you are currently experiencing: _____

_____

_____

2. How would you rate your current sleeping habits? Poor □ Satisfactory □ Good Very □

Please list any specific sleep problems you are currently experiencing: None □ _____

_____

3. What types of exercise do you participate in and how frequently?_____

4. Please list any difficulties you experience with your appetite or eating problems:

None □ _____

5. Are you currently experiencing overwhelming sadness, grief or depression? Yes □ No □

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias?

Yes □ No □ If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes □ No □

If yes, please describe: _____

8. How many times per week do you drink alcohol? _____ When you do drink, what

type of beverage do you drink, and how much? _____

9. How often do you engage in recreational drug use? Daily □ Weekly □ Monthly □ Never □

10. Are you currently in a romantic relationship? No □ Yes □ If yes, for how long?_____

On a scale of 1-10, how would you rate your relationship? _____

11. What are the biggest challenges you have with your personal relationship? _____

_____

_____

12. What significant life changes or stressful events have you experienced recently? _____

_____

_____

13. Who is your primary care physician (name, phone and address): _____

_____

Has client ever had problems with:

Seizure/epilepsy	Y N _____	Drug Abuse	Y N _____
Diabetes	Y N _____	Heart Problems	Y N _____
Lung Disease	Y N _____	Thyroid Disease	Y N _____
Tuberculosis	Y N _____	Kidney Disease	Y N _____
High Blood Pressure	Y N _____	Anemia	Y N _____
Hepatitis	Y N _____	Trouble with seeing	Y N _____
STDs	Y N _____	Trouble Hearing	Y N _____
Head Injury	Y N _____	Chronic Pain	Y N _____
Alcohol Abuse	Y N _____	Asthma	Y N _____

Medical Hospitalizations client has had in the past? (Surgeries, Illness, accidents, etc.)

Reason	Date

Current Medications (Including prescription, over the counter or herbal medicines)

Name of Medicine	Dose	Given for

Do you have any allergies to food, medications or other things? [ ] Y [ ] N _____

Family Mental Health History: In the section below identify if there is a family history **or if you have any issues** with any of the following. If yes, please indicate the family member's relationship to you (father, maternal grandmother, paternal uncle, etc.).

Alcohol/Substance Abuse: yes/no _____

Anxiety: yes/no _____

Depression: yes/no _____

Bipolar Disorder: yes / no _____

Domestic Violence: yes/no _____

Eating Disorders: yes/no _____

Obesity: yes/no _____

Obsessive Compulsive Behavior: yes/no _____

Schizophrenia: yes/no _____

Suicide Attempts: yes/no _____

Homicide or Attempts: yes / no _____

Sexual Abuse of client or other family members yes/no_____

_____

Please check all of the behaviors and symptoms that you consider a problem:

- □ Distractibility
- □ Hyperactivity
- □ Impulsivity
- □ Boredom
- □ Poor memory
- □ Confusion
- □ Seasonal mood changes
- □ Sadness/depression
- □ Loss of pleasure/interest
- □ Hopelessness
- □ Thoughts of death
- □ Self-harm
- □ Crying spells
- □ Loneliness
- □ Low self-worth
- □ Guilt/shame
- □ Fatigue
- □ Change in appetite
- □ Lack of motivation
- □ Withdrawal from people
- □ Anxiety/worry
- □ Panic attacks
- □ Specific fears
- □ Social discomfort
- □ Obsessive thoughts
- □ Compulsive behavior
- □ Aggression/fights
- □ Frequent arguments
- □ Irritability/anger
- □ Homicidal thoughts
- □ Flashbacks
- □ Hearing voices
- □ Visual hallucinations
- □ Suspicion of others
- □ Racing thoughts
- □ Excessive energy
- □ Mood swings
- □ Sleep problems
- □ Nightmares
- □ Eating problems
- □ Gambling problems
- □ Computer addiction
- □ Pornography problems
- □ Parenting problems
- □ Sexual problems
- □ Relationship problems
- □ Work/school problems
- □ Alcohol/drug use
- □ Recurring bad memories or nightmares

Additional Information:

1. Are you currently employed? _____If yes, employer? _____

Is there anything stressful about your current work? _____

2. Describe your spiritual faith or belief (if any): _____

3. Where were you born and raised? _____

4. Describe the family who raised you: (how many siblings, quality of relationships):

_____

_____

5. Describe current family relationships: (significant other? children? quality of relationships?):

_____

_____

6. Describe past significant relationships (marriages, divorces, separations, etc.):

_____

_____

7. Describe any significant losses/separations of any family members/significant others (including loss of pets, physical functions, property/possessions, etc.):

_____

_____

8. Describe current housing situation (house, mobile home, boarding homes, shelter, homeless, etc.): Any needs? _____

9. Any problems/issues/changes with sex/sexuality?

_____

_____

10. Describe current social involvement (activities that you enjoy with others):

_____

_____

11. Describe educational background (how far in school, tech school, college, special ed., special programs, highest level completed):

_____

12. History of legal involvements, as well as any current legal problems:

_____

13. Have you experienced any past traumas? (sexual, accidents, domestic violence, …)

_____

_____

14. What would you like to accomplish out of your time in therapy?

_____

_____

15. How will you or your life be different when you are ready for discharge from therapy? Complete this sentence…

I will be ready for discharge when… _____

_____

_____

Strengths, Needs, Abilities and Preferences:

Strengths: (Family, social, spiritual & hobbies that have helped overcome past crises):

_____

Needs: (Client's expression of current needs: emotional, physical & environmental):

_____

Abilities: Client's ability to follow up with treatment: Yes/No

Client understands instructions & is willing to participate in treatment: Yes/No

Preferences: Appointment day/evening (circle).

Are you currently seeking treatment from another provider: Yes/No

OFFICE USE ONLY:

MENTAL STATUS				
Affect	• Appropriate	• Blunted	• Constricted	• Flat • Labile
Appearance	• Well-groomed	• Disheveled	• Inappropriate	
Attitude	• Cooperative	• Guarded	• Uncooperative	
Mood	• Euthymic	• Depressed	• Anxious	• Euphoric
Motor Activity	• Calm	• Hyperactive	• Agitated	• Tremors/Tics
Thought Process	• Intact	• Circumstantial	• Tangential	• Loose assoc.
Thought Content	• Appropriate	• Hallucinations	• Delusions	
Orientation	• Fully oriented	Disoriented as to: • Time • Place • Person		

Diagnosis:

_____

Criteria for Diagnosis:

_____

Therapist Name: _____

Therapist Signature: _____ Intake Date: _____