2 - Clinical Assessment

Client Name: ________________________________ **Date:** __________

Presenting Problem - client's initial explanation of the problem(s), duration and precipitant cause.

Observations - therapist's observations of client's presentation and family interactions.

Pertinent History - any prior therapy {including family, social, psychological, and medical).

Family/Psychosocial Assessment -

Clinician: ________________________________

ICD: ________________________________

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Maple Counseling Center

Transformational Psychotherapy

Involvement in Treatment -

Cultural Variables? If yes, explain.

Estimated Treatment Length -

Special Needs of Client - ex: Needs interpreter, religious consultant, etc.

Educational or Vocational -

Diagnostic Impressions -

Strengths -

Other Information -

Risk - evidence of potential or actual risk(s); select and explain.

- [ ] Anxiety
- [ ] Depression
- [ ] Adjustment Issues
- [ ] Emotional Abuse
- [ ] Physical Abuse
- [ ] Anger Issues
- [ ] Substance Abuse
- [ ] Drug Addiction
- [ ] Death or Grieving Issues
- [ ] Chronic Pain
- [ ] Suicidal Actions
- [ ] Suicidal Thoughts
- [ ] Financial Issues
- [ ] Legal Issues
- [ ] Family Issues
- [ ] Court Ordered
- [ ] Reconciliation
- [ ] PTSD
- [ ] Trauma
- [ ] Headaches
- [ ] Relationship Issues
- [ ] Divorce
- [ ] Separation
- [ ] Sexual Issues
- [ ] LBGT
- [ ] Communication Issues
- [ ] Self-esteem / Self-worth
- [ ] Eating Disorder
- [ ] Medical Issues
- [ ] Back Issues

Assigned Therapist - ___________________________________ **Date:** ____________