



Redwood Therapy Group: Assessment Form

Name: _____ Date: _____ Age: _____ Gender: Male/ Female

***Past History of Therapeutic Treatment** (type, duration, when, presenting problem, effectiveness, why discontinued,):

***Attempts to Resolve Presenting Problem** (techniques/resources, duration, effectiveness):

***Risk Factors** (Are there any thoughts, feelings etc.) (Suicide, Homicide, Eating Disorder, Domestic Violence):

***Spirituality** (personal level, interaction with clergy/bishop, attendance at church, comfort using in therapy):

***Strengths and Support System** (friends and family support, personal strengths, commitment to make changes):

***Challenges** (roadblocks)

***Client's Presenting Problem** (physical and emotional symptoms onset, intensity, frequency, contributing factors,) (Assess for sleep, appetite change, mood swings, hallucinations, obsessions):

***Relationship Status** (length of relationship, satisfaction, previous relationships):

***Individuals Living in the Home** (Please write the name, relation and age).

***Other Immediate Family Members Not Living In The Home** (Please write the name, relation and age).

***Employment** (company, length, satisfaction, title)

***Education** (highest level completed, learning disabilities, strengths, weaknesses)

***Medical History** (any major personal and family history, surgeries, diagnosis etc.)

***Current Medications** (name, purpose, dosage, effectiveness, duration, Doctor prescribing medication, confidence in Dr. prescribing medication)

***Dependence/Usage History** (drug and alcohol, sexual, pornography, video game/computer, impulsive spending, gambling: personal and extended family)

***History of Abuse** (physical, sexual, rape, trauma: when, how long, report made, current safety measures if necessary)

***Mental Health History** (depression, anxiety, bipolar, schizophrenia, psychiatric hospitalization, personal and extended family):

***Goals Client wishes to accomplish through therapy:**

Person Filling out form Signature: _____ Date _____

Please print your name: _____

Therapist's Signature: _____ Date _____