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**Client Assessment Form (Post-Consultation)**

| **Section** | **Details/Instructions** |
| --- | --- |
| **Client Information** |  |
| Full Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Assessment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Presenting Issues** |  |
| Please describe the emotional challenges or relationship concerns you are currently facing: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How would you rate the distress these issues cause you on a scale from 1 to 10? (1 = Not Distressed, 10 = Extremely Distressed) | [] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 |
| **Self-Esteem and Identity** |  |
| How do you generally view yourself in terms of self-worth and confidence? | [ ] Positive [ ] Unsure [ ] Low [ ] Highly Self-Critical |
| Do you struggle with feelings of inadequacy or insecurity in any areas of your life? | [ ] Yes [ ] No |
| If yes, please describe: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you feel like societal expectations (e.g., body image, gender roles) impact how you see yourself? | [ ] Yes [ ] No |
| **Relationship Patterns** |  |
| How would you describe your current relationships (family, friends, romantic partners)? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you noticed repeating patterns in your relationships? | [ ] Yes [ ] No |
| If yes, please describe: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a history of difficulties in past relationships? | [ ] Yes [ ] No |
| If yes, please describe: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Emotional Health and Coping Mechanisms** |  |
| Do you have any history of emotional challenges (e.g., depression, anxiety, trauma)? | [ ] Yes [ ] No |
| If yes, please briefly describe: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How do you typically cope with emotions like anger, sadness, or frustration? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How do you deal with conflict in relationships? | [ ] Avoidance [ ] Passive-Aggressive [ ] Open Communication [ ] Emotional Outbursts [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Trauma and Healing** |  |
| Have you experienced any significant emotional or physical trauma that you feel impacts your life now? | [ ] Yes [ ] No |
| If yes, please provide details: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you feel that past experiences are affecting how you engage in current relationships or your self-esteem? | [ ] Yes [ ] No |
| **Goals for Therapy and Treatment** |  |
| What are the most important things you want to work on in therapy? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What changes would you like to see in yourself or your relationships by the end of therapy? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Treatment Preferences** |  |
| Are you open to integrating psychoeducation into our sessions to better understand your emotions and behaviours? | [ ] Yes [ ] No |
|  |  |
| Do you have any preferences regarding the therapy approach? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Additional Information** |  |
| Is there anything else you think would be helpful for me to know as we begin our work together? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Consent for Therapy Plan** |  |
| I understand that the information provided will be used to guide my therapy plan. | [ ] Yes [ ] No |
| I consent to participate in therapy to address my emotional and relational health. | [ ] Yes [ ] No |

**Date:**

**Signature:**