CLIENT ASSESSMENT

LIFE SKILLS PLUS, INC.

PATIENT'S NAME (Last Name, First Name, Middle Initial)

Presenting Problem:
Symptom details;

Functional Impairments;

Why now?

Symptom Onset and Duration:

Symptom Impact on Daily Life:

Previous Efforts at Self-Help:

Priority Symptoms, behaviors, skill or functional deficits to treat:

PREVIOUS COUNSELING

Previous Counselor: Counselor's Phone #

Counselor Address:

Dates(s)	Diagnosis	Interventions (level of care)	Response

Inpatient Care Provider, Dates, Results

Substance Abuse
Current Drugs used:
Past Drugs used:
Cigarettes:
Alcohol:
Previous Treatment:

Medical Doctor: Doctor's Phone #

Doctor's Address:

Date Well Child Exam Completed?

Last Physical Exam:

CLIENT ASSESSMENT

General Medical Information

Health Problems: .....
Dental Problems; .....
Developmental Delays; .....
Surgeries: .....

Serious Accidents: .....

Allergies: .....

Psycho tropic Medication	Dosage	Schedule	Route	Start Date	End Date
				/	
				/	
				/	
				/	
				/	
				/	
				/	

Name & phone number of prescribing physician for above medications:

Name: _____ **Phone #:** _____

LIST PAST PSYCHO TROPIC MEDICATIONS USED: _____ **NONE**

Over the counter remedies: **Intensive Family Interventions**

Relevant Conditions Affecting the Member or Family;

Psychological;

Emotional;

Behavioral;

History of Abuse;

History of Violence;

Legal Involvement;

Military History;

Family Medial History;

Any Other Condition: