Assessment & Goals

PAUL MYERS, Ph.D., LLC
LICENSED PSYCHOLOGIST

Name:

Date:

Reason/Concern/Problem:

How long has it been a concern?

What is the worst it has been?

What has relief from the problem looked/sounded/acted like? *(For example, does it ever go away completely?)*

What do you hope for as goals or results?

Do you have thoughts or actions of self-harm? *(Please describe.)*

Do you have thoughts or actions of harm towards others? *(Please describe.)*

What have you done to treat, stop, or address your concerns?

What medications are you currently taking, for what, and in what dosages?

Who is your primary doctor? And if you have other treatment providers, who are they, and what do they treat?

Do you use complimentary or alternative medications, remedies, or treatments? And if so, what are they and to treat what?

Do you use alcohol, tobacco, or other drugs recreationally, or to treat your concerns or symptoms? If so, how much, how often?

Who is in your immediate family and indicate which ones you turn to for support or assistance:

Is there a work or school consequence to your situation, and if so, what is it?

Has there been a change in your sleeping, eating, exercising, sexual interest, or enjoyment of things you typically like? If so, in what ways?

Is there a spiritual, meaning/purpose, or religious dimension to the concerns that brought you in for this work together?

Have you ever been hospitalized? If so, for what, and when?

Please provide a name and phone number for someone you would want me to call in the event of an emergency:

Name: _____ Phone: _____