SELF ASSESSMENTS I –VII **CLIENT NAME/#_____**

Please rate each of the following items according to how frequently you experience each one:

I. PERCEPTUAL STATES *"How often do I...*	0 never	1 once in a while	2 frequently	3 so often that it interferes with my daily functioning.
Realize I am daydreaming when someone else is talking				
Feel like I am outside of my body watching myself do something				
Wonder whether something really did happen or was just from a dream				
Find that I have been sitting and staring off into space without realizing the passage of time				

II. SAFETY *"How often do I...*	0 never	1 once in a while	2 frequently	3 so often that it interferes with my daily functioning.
Use prescription or other drugs to control my emotions				
Use alcohol to relax when I am alone or in social settings				
Have thoughts about hurting myself or others				
Feel like my life is not worth living				

III. MOOD DISTURBANCE *"How often do I...*	0 never	1 once in a while	2 frequently	3 so often that it interferes with my daily functioning.
Wake up in a bad mood and it lasts almost all day				
Start a project and find that I cannot stop working on it until it is finished				
Feel hopeless or powerless about my future				
Get so angry that I go into a ñblind rage,ò say and doing things which I later regret				

IV. SELF ESTEEM *"How often do I...*	0 never	1 once in a while	2 frequently	3 so often that it interferes with my daily functioning.
Think that I cannot do anything right				
Keep quiet in a group for fear people will think I am stupid if I say something				
Avoid conflict because I do not want hurt someoneôs feelings or have someone mad at me				
Worry that I will be in trouble for not meeting expectations of others				

V. SELF-ASSESSMENT OF DAILY FUNCTIONING CLIENT NAME/#_____

Rate each of the following areas of your daily life according to how well you believe you are functioning. In other words, how satisfied are you with how well you are managing your life in each of these areas?

PHYSICAL FUNCTIONING	**0 NA**	**1 I am dissatisfied**	**2 I am satisfied**	**3 I am more than satisfied – I am fulfilled**
Nutrition				
Exercise				
Sleep				
Overall health				

INTELLECTUAL FUNCTIONING	**0 NA**	**1 I am dissatisfied**	**2 I am satisfied**	**3 I am more than satisfied – I am fulfilled**
Work performance				
School performance				
Ability to learn new things				
Memory				

EMOTIONAL FUNCTIONING	**0 NA**	**1 I am dissatisfied**	**2 I am satisfied**	**3 I am more than satisfied – I am fulfilled**
Mood stability				
Happiness				
Hopefulness				
Emotion regulation				

SOCIAL FUNCTIONING	**0 NA**	**1 I am dissatisfied**	**2 I am satisfied**	**3 I am more than satisfied – I am fulfilled**
Family relationships				
Friends				
Recreation				
Overall social skills				

SPIRITUAL FUNCTIONING	**0 NA**	**1 I am dissatisfied**	**2 I am satisfied**	**3 I am more than satisfied – I am fulfilled**
Purpose in life				
Spiritual practice				
Personal integrity				
Overall sense of connectedness				

ENVIRONMENTAL FUNCTIONING	**0 NA**	**1 I am dissatisfied**	**2 I am satisfied**	**3 I am more than satisfied – I am fulfilled**
Living environment				
Time management				
Financial management				
Household chores				

VI. SELF ASSESSMENT OF LIFE HISTORY CLIENT NAME/#_____

For each of the sections below, complete the sentence stems and write 1-2 sentences about a memory that you have from that time in your life. Use back of sheet if you need extra room.

Early Childhood – Ages Birth through 5

I was born on (date)_____ in (place)_____ the (#)_____ of (#children)_____

I lived with _____

Memory:

Childhood – Ages 6 through 12

When I started school, I _____

My best friend was_____

Memory:

Adolescence – Ages 13 through 18

My social life is/was_____ _____

My home life is/was _____

Memory:

Young Adulthood – Ages 19 through 29

My goal in life was/is/will be_____ _____

I spent/spend/will spend most of my time doing _____

Memory:

Adulthood – Ages 30+

My best friend was/is/will be_____ _____

I hoped/hope/will hope that_____ _____

Memory:

VII. Self report LIST OF MEDICATIONS **CLIENT NAME/#_____**

Medication	Dose	# times/day	Purpose

Continue on back if needed

Prescribing Physician(s):_____

In the space below, briefly describe any physical health problems that you think are relevant to your mental health care: