



**TOTAL HEALTH CONCEPTS, LLC**  
**(703) 255-7012 / FAX (703) 255-6171**

*Nutrition, Fitness, and Psychotherapy Professional Services*

*Please Print Clearly*

**Counseling Assessment Form**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Address: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Marital Status: S M D W Name of Spouse: \_\_\_\_\_ Years Married: \_\_\_\_\_  
 Length of previous marriages: \_\_\_\_\_

Children Names	Age	Sex	Any physical conditions or concerns?
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

Please fill in the names and phone numbers of the professionals from whom you are currently receiving treatment

Physician: _____	Phone: _____
Psychiatrist: _____	Phone: _____
Therapist/Psychologist: _____	Phone: _____
Nutritionist: _____	Phone: _____
Other: _____	Phone: _____

Who referred you to Total Health Concepts? \_\_\_\_\_

Medical Diagnosis/ Primary Concerns or Problems \_\_\_\_\_

***This comprehensive assessment provides us with information that assists us in helping clients with a variety of health issues. Please fill out the sections that apply to your treatment. If you have difficulty or feel uncomfortable filling out any sections, leave them blank and your counselor/therapist will review them with you during your first session.***

**Personal Health Profile**

1) When was your last physical examination? \_\_\_\_\_

2) Have you / your family ever been treated for or have a history of:

	You	Parents	Siblings	Extended Family
Abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol/triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity (20+ lbs overweight)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other chronic or serious health problems/symptoms: \_\_\_\_\_

Please list any hospitalizations / surgeries / in-patient treatments you have had and your age at the time: \_\_\_\_\_

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**Medications/Supplements**

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Please list all current medications, dosage, and prescribing physician:

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Do you take:

Vitamin/Mineral Supplements: \_\_\_\_\_

Aspirin/Ibuprofen: \_\_\_\_\_

Other: \_\_\_\_\_

**Family History Profile**

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Family of Origin:

Mother: DOB \_\_\_\_\_ Age \_\_\_\_\_

DOD \_\_\_\_\_ Age \_\_\_\_\_

General health: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Cause of death or poor health: \_\_\_\_\_

Father: DOB \_\_\_\_\_ Age \_\_\_\_\_

DOD \_\_\_\_\_ Age \_\_\_\_\_

General health: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Cause of death or poor health: \_\_\_\_\_

Birth Order: \_\_\_\_\_ of \_\_\_\_\_ children

Names and Ages of Siblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parented (check those that apply):

\_\_\_\_\_ Traditional Family    \_\_\_\_\_ Single Parent    \_\_\_\_\_ Adopted/Foster    \_\_\_\_\_ Other

All People Living in Household during childhood:

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Your role/behavior in your family during childhood (check all that apply):

\_\_\_\_\_ Caretaker    \_\_\_\_\_ Controller    \_\_\_\_\_ Pleaser    \_\_\_\_\_ Need to be needed

\_\_\_\_\_ Passive/Avoider    \_\_\_\_\_ Dependent/Needy    \_\_\_\_\_ Angry/Aggressive

Explain: \_\_\_\_\_

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Please list any past family issues or information we should be aware of: \_\_\_\_\_

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**Personal Lifestyle Profile**

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Educational History:

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Vocational History/Employment:

Past: \_\_\_\_\_

Current: \_\_\_\_\_

Please indicate where your life schedule falls on the scale:

**Perceived Level of Commitment/Busyness**

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1	2	3	4	5	6	7	8	9	10
Under Involved		Flexible		Manageable		Tight Schedule		Very Tight Schedule	

Are you over-functioning, under-functioning, or balanced in the time you spend in the following areas?

	Over-functioning	Under-functioning	Balanced
Personal Time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work/Occupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Estimate the amount of time spent in each of the following areas (in hours per day or week):

_____ Work/School	_____ Spouse	_____ Children
_____ Other Family	_____ Social/Friends	_____ Hobbies
_____ Personal Time	Other: _____	

Hobbies/Sports/Recreational Activities:

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Cultural/Spiritual/Volunteer Activities:

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**Stress Profile**

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	Yes	No
Do you feel in control of your life?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you have enough personal time?	<input type="checkbox"/>	<input type="checkbox"/>
Do you make time to relax at least 15 to 30 minutes per day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you like your job/school?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have friends and enjoy social events?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find your family situation stressful?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a history of alcoholism (father/mother)?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a history of sexual/physical/emotional abuse?	<input type="checkbox"/>	<input type="checkbox"/>

Recent death in family?

What situations are you dealing with at the present time that may be causing undue stress? Check all that apply:

\_\_\_\_\_ Work related issues      \_\_\_\_\_ Marriage problems      \_\_\_\_\_ School related issues  
\_\_\_\_\_ Family issues      \_\_\_\_\_ Time management issues      \_\_\_\_\_ Financial issues

Legal Problems (arrests, convictions, court ordered treatment):

\_\_\_\_\_

Sexual History:

\_\_\_\_\_ Heterosexual      \_\_\_\_\_ Homosexual      \_\_\_\_\_ Bisexual      \_\_\_\_\_ Other

Other: \_\_\_\_\_  
\_\_\_\_\_

How do you cope with stress? Check all that apply:

\_\_\_\_\_ Talk to Friend/Family Member      \_\_\_\_\_ Read      \_\_\_\_\_ Music  
\_\_\_\_\_ Pets      \_\_\_\_\_ Physical Activity      \_\_\_\_\_ Prayer/Meditation      \_\_\_\_\_ Anti-depressants  
\_\_\_\_\_ Hobbies      \_\_\_\_\_ Food      \_\_\_\_\_ Alcohol      \_\_\_\_\_ Smoking  
\_\_\_\_\_ Drugs      \_\_\_\_\_ Caffeine      \_\_\_\_\_ Relaxation exercises      \_\_\_\_\_ Work  
\_\_\_\_\_ Nothing, I keep it in

Other: \_\_\_\_\_

Describe the current stressors or problem situations are you experiencing:

\_\_\_\_\_

### **Self-Esteem Profile**

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My internal thoughts about myself are:

\_\_\_\_\_ Positive      \_\_\_\_\_ Neutral      \_\_\_\_\_ Negative

Describe: \_\_\_\_\_  
\_\_\_\_\_

My confidence level is:

\_\_\_\_\_ High      \_\_\_\_\_ Neutral      \_\_\_\_\_ Low

Areas where I feel confident: \_\_\_\_\_  
 Areas where I do not feel confident: \_\_\_\_\_

Do your thoughts tend to be all-or-nothing or black-and-white thinking?  
 \_\_\_\_\_

Do you feel good about what others think of you? \_\_\_\_\_  
 \_\_\_\_\_

How would you describe your self-worth / value to yourself and others? \_\_\_\_\_  
 \_\_\_\_\_

When you look in the mirror are you happy with what you see? \_\_\_\_\_  
 \_\_\_\_\_

**Behavioral Profile**

Your current role/behavior in your life (check all that apply):  
 \_\_\_\_\_ Caretaker    \_\_\_\_\_ Controller    \_\_\_\_\_ Pleaser    \_\_\_\_\_ Need to be needed  
 \_\_\_\_\_ Passive/Avoider    \_\_\_\_\_ Dependent/Needy    \_\_\_\_\_ Angry/Aggressive  
 Other: \_\_\_\_\_

	Please check box with to indicate appropriate frequency of use					More than 1x/day
	Less than 1x / month	1-5x/month	1x/week	1-6x/week	1x/day	
Caffeine						
Cigarettes						
Alcohol						
Marijuana						
Other						

**Sleep Pattern:**

How many hours do you sleep at night? \_\_\_\_\_  
 Do you have trouble falling asleep at night? How often and why? \_\_\_\_\_  
 \_\_\_\_\_  
 Do you wake up during the middle of the night? How often and why? \_\_\_\_\_  
 \_\_\_\_\_  
 Are you tired during the day? How often? \_\_\_\_\_  
 Do you sleep/nap during the day? How often and for how long? \_\_\_\_\_  
 \_\_\_\_\_

**Goals:**

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Please describe the goals you would like to achieve in the following areas of your life

Personal:

Marital/Family:

Behavioral:

Other:

What expectations and goals do you have for your counseling/therapy?

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