Lacamas Counseling & Psychiatry
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Camas, WA 98607
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info@lacamascounseling.com

LACAMAS COUNSELING

REASSESSMENT

Full name: _____ **Date:**_____

Parent/Legal Guardian: _____

IF INFORMATION HAS BEEN CHANGED, THEN PLEASE UPDATE

Address: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone Number(s): _____ Ok to leave a message? □YES □NO

_____ Ok to leave a message? □YES □NO

Email address: _____ Ok to send a message? □YES □NO

Emergency Contact Name & Phone: _____

What are your current stressors, concerns, or problems?

_____

_____

_____

What progress/changes have you noticed over the last 6 months?

_____

_____

What coping skills, strengths, or resources have been effective in managing your symptoms or concerns?

_____

_____

What are your continuing goals or new goals?

_____

_____

Do you experience any thoughts/intentions of harming yourself or others?

_____

_____

_____

Describe any addictions or addictive behaviors that continue to affect you

_____

_____

If you're medical providers have changed, please provide updated information

Primary Care Physician Name _____
Phone Number _____
Clinic Name _____

Other Medical Provider _____
Phone Number _____
Clinic Name _____

Other Medical Provider _____
Phone Number _____
Clinic Name _____

What medications or supplements are you taking, and for what reason?

_____

_____

List any medical conditions, health problems, or hospitalizations that have impacted you over the last 6-9 months

_____

_____

How satisfied are you with the service that you are receiving (i.e. counseling sessions, phone calls, emails, office environment, timeliness, etc.)

_____

_____

What's your understanding of your diagnosis/mental health concerns?

_____

_____

Are you anticipating any upcoming changes in life?

_____

_____

What else would you like me to know?

_____

_____

Check any of the following symptoms that have impacted you in the last six months

Depressed Mood
Tiredness/Fatigue
Low energy
Tearfulness
Hopelessness
Apathy/Lack of care
Loss of interest/pleasure
Low self-worth
Low motivation
Isolation from others
Difficulty concentrating
Racing thoughts
Lack of confidence
Increased appetite
Decreased appetite
Irregular sleeping
Anxiety
Panic
Fear
Social anxiety
Panic attacks
Thoughts of harming another person
Suicidal thoughts
Self-harm
Guilt/Shame
Inconsistent mood changes
Excessive Energy
Impulsivity
Compulsive Behaviors
Obsessions
Hear/see things others do not
Paranoia/Suspicion
Reckless Behaviors
Exposure to traumatic event
Flashbacks (while awake)
Nightmares
Avoidance of trauma reminders
Easy startle reflex
Irritability/Anger
Frequent anger outbursts
Other symptoms _____

What stressors/changes have recently impacted you?

Burnout/Stress
Excessively busy
Relocation/Recent move
Career/Job
Retirement
Unemployment
Medical/health
Legal matters
Finances
Finding meaning & purpose
Identity
Religion/spirituality
Parenting difficulties
Divorce/Separation
Grief/Loss
Sexual abuse/rape
Emotional abuse/control
Physical abuse
Residual problems from childhood abuse
Alcohol/drugs
Post-partum transitions
Infertility/Miscarriages
Abortion
Social life
Extended family
Chaotic life
Something else _____

How are these symptoms and stressors affecting your every day life?

Personally _____
Family _____
Friendships _____
Social life _____
Work/School _____
Every day tasks _____