History and Goals Assessment Form

Name:_____ Date:_____

Date of Birth:_____ Gender: _____

Address: _____

Phone Number(s), if it is o.k. to leave a message: _____

Email Address:_____

Please fill in the blanks below from the time of conception to present day with the significantly threatening, frightening, hurtful or difficult events or situations that were experienced. If the event(s) is/are not recalled (e.g., in utero, birth trauma, etc.) please list them, as well.

Please circle the things that you believe have been the most impacting.

Details are not needed, at this point. However, feel free to provide more information on a separate sheet, if you wish.

Example: 11-15 years of age: bullied in school, fights between parents, _____

0-2 years of age:_____

_____

3 - 5 years of age:_____

_____

6 - 8 years of age:_____

_____

9 - 11 years of age:_____

_____

12 - 14 years of age:

15 - 18 years of age:

19-25:

26-35:

36-present:

What has caused you to seek treatment now?

Please list your 5 main symptoms in order of severity/intensity and disruption.

What diagnoses have been given in the past?

Name and relationship of the person who completed this form: