Naper Clinical Behavioral Services
800 East Diehl Road • Suite 100 • Naperville, Illinois 60563
Office (630)577-1577 Fax (630)577-1555

SELF ASSESSMENT

Please fill out the following information to the best of your knowledge.

Name (Legal)_____ **Today's date**_____
Please print

Preferred name_____ ***Preferred pronoun***_____

Primary Care MD	First seen and Last seen	Address	Phone
Psychiatrist	First seen and Last seen	Address	Phone

Current and past medical conditions_____

Current Symptoms from past 30 days (please check all that apply):

Mood
- ☐ stable
- ☐ low
- ☐ high
- ☐ changes frequently
- ☐ sad

Sleep
- ☐ too much
- ☐ cannot fall asleep
- ☐ awakens throughout night
- ☐ normal

Energy
- ☐ normal
- ☐ high
- ☐ low

Substance abuse
- ☐ alcohol
- ☐ marijuana
- ☐ prescription drugs
- ☐ heroin
- ☐ cocaine
- ☐ over-the-counter drugs
- ☐ other_____

Concentration
- ☐ normal
- ☐ poor
- ☐ decreased ability to focus
- ☐ increased forgetfulness

Interests
- ☐ social withdrawal
- ☐ loss of pleasure
- ☐ loss of desire for usual activities
- ☐ normal
- ☐ loss of desire for sex

Appetite
- ☐ normal
- ☐ increased
- ☐ decreased
- ☐ vomiting

Child Issues
- ☐ bedwetting
- ☐ isolative
- ☐ bullied
- ☐ Other_____

Anxiety
- ☐ occasional
- ☐ constant
- ☐ panic
- ☐ irritable
- ☐ feel guilty
- ☐ fears

Safety concerns
- ☐ none
- ☐ thoughts of hurting self
- ☐ suicidal
- ☐ thoughts of hurting someone else
- ☐ cutting or scratching behaviors

School Functioning
- ☐ frequent absences
- ☐ peer difficulties
- ☐ poor grades
- ☐ learning disability
- ☐ normal
- ☐ avoiding

Other areas of concern
- ☐ shopping
- ☐ gambling
- ☐ sexual promiscuity
- ☐ pornography
- ☐ over eating
- ☐ obsessions/compu

Naper Clinical Behavioral Services
800 East Diehl Road • Suite 100 • Naperville, Illinois 60563
Office (630)577-1577 Fax (630)577-1555

Name_____ Date of birth_____

What medication	How much	When	Prescribed by:

Do we have your permission to leave appointment times and date information on your phone? Circle Yes or no

Phone_____

Signature: _____Date:_____

\

If patient is a child/adolescent please fill out below:

Mother's name_____phone #(____)_____
Address_____
Mother's maiden name_____

Father's name_____phone #(____) _____
Address_____

With whom does the child/adolescent primarily reside? _____

Name of school_____ Grade Level_____

School Counselor's Name and phone number _____