# Therapist Evaluation Form

The following evaluation will help us determine if Room to Heal can provide the appropriate level of services.

Client Name:

Client DOB:

Client’s sexually addictive behaviors and highest level of acting out:

On a scale of 1-10 (1 = extremely self-aware, 10 = extreme denial) how severe is the client’s denial about the addiction and its consequences?

On a scale of 1-10 (1 = not motivated at all, 10 = extremely motivated) how motivated is the client to establish and maintain recovery?

Other Addictions or Compulsive Behaviors:

* Alcohol
* Drugs:
* Prescriptions:
* Video Games
* Social Media
* Other:

Is sex addiction their primary addiction? (yes/no)

Do you think this person is capable of staying sober from all alcohol and drugs during their stay at Room to Heal? If not - please elaborate:

Is child pornography a concern?

Has this person been diagnosed with any mental disorders? (Bipolar, Schizophrenia, etc)

If so, would you consider them stabilized with medication? If yes, how long have they been stable?

Is this person potentially a harm to themselves or others?

Are they married? What is the status of their current relationship?

Client’s identified sexual orientation:

Is there anything else we should consider when evaluating this person for Room to Heal?