

Client Checklist of Concerns

CURRENT SYMPTOM CHECKLIST: (check mark the rate the intensity of symptoms currently present)

None= This symptom is not present at this time. **Mild=** Impacts quality of life, but no significant impairment of day-to-day functioning. **Moderate=** Significant impact on quality of life and/or day-to-day functioning. **Severe=** Profound impact on quality of life and/or day-to-day functioning.

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Depressed mood					Hallucinations: visual				
Appetite disturbance					Hallucinations: audio				
Sleep disturbance					Dissociative states				
Fatigue/low energy					Significant weight gain/loss				
Poor Concentration					Anorexia				
Worthlessness					Binge eating				
Hopelessness					Purging/vomiting				
Mood Swings					Laxative/diuretic use				
Emotionality/labile					Substance abuse				
Elevated mood					Somatic complaints				
Agitation					Sexual dysfunction				
Anger/Irritability					Self-mutilation				
Social isolation					Guilt				
Conduct problems					Grief				
Oppositional behavior					Domestic Violence (V) *				
Aggressive behaviors					Domestic Violence (P)*				
Hyperactivity					Emotional trauma (V)*				
Generalized anxiety					Emotional trauma (P)*				
Panic attacks					Physical trauma (V)*				
Phobias					Physical trauma (P)*				
Obsessions					Sexual trauma (V)*				
Compulsions					Sexual trauma (P)*				
Delusions					Suicidal Thoughts				

* V=victim P=perpetrator

MEDICAL HISTORY: (check all that apply)

Describe your current physical health:

Excellent Good Fair Poor

Allergies:	Diabetes	Lupus
Alzheimer's disease/dementia	Fibromyalgia/Epstein-Barr	Migraines
Arthritis (osteo)	Gastro-intestinal difficulties	PMS/PMDD
Arthritis (rheumatoid)	Head injury	Stroke
Cancer (type):	Heart disease	Thyroid Problem
Chronic pain	High blood pressure	
Other serious health problems		

Comments: _____

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FAMILY HISTORY: (mark all that apply in each box)

During childhood:	Present for entire childhood:	Present for part of childhood:	Not present at all:
Mother			
Father			
Stepmother			
Stepfather			
Brother(s)			
Sister(s)			
Grandparents			
Other (specify)			

Parents' Current Status:	
Married to each other _____ (years/months)	
Separated for _____ (years/months)	
Divorced for _____ (years/months)	
Mother remarried _____ times	
Father remarried _____ times	
Mother involved with someone Yes No	
Father involved with someone Yes No	
Mother deceased for _____ years at age _____	
Father deceased for _____ years at age _____	

Describe Childhood Family Experience:	
Normal home environment	
Chaotic home environment	
Experienced neglect	
Witnessed physical/verbal/sexual abuse toward others	
Experienced physical/verbal/sexual abuse from others	

RELATIONSHIP HISTORY:

Current Relationship Status:	
Single	
Living together _____ (years/months)	
Engaged _____ (years/months)	
Common law _____ (years/months)	
Married for _____ (years/months)	
Life-partnered _____ (years/months)	
Separated for _____ (years/months)	
Divorce in progress _____ (years/months)	
Divorced for _____ (years/months)	
_____ prior marriages (self)	
_____ prior marriages (partner)	

Intimate Relationship:	
Never been in a serious, intimate relationship	
Not currently in an intimate relationship	
Currently in a serious, intimate relationship	
Multiple intimate relationships	

Relationship Satisfaction:	
Very satisfied with relationship	
Satisfied with relationship	
Somewhat satisfied with relationship	
Dissatisfied with relationship	
Very dissatisfied with relationship	

SUBSTANCE USE HISTORY: (check all that apply in each box)

Current Alcohol/ Drug Use Status:			
Active use		Active abuse	
No history of abuse		Early full remission	
		Early partial remission	
		Sustained full remission _____ mos./yrs.	

Comments: _____

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SOCIO-ECONOMIC HISTORY: (mark all that apply in each box)

Activities:	
Currently active in community/recreational activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:
Formerly active in community/recreational activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:
Currently engaging in hobbies?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:
Formerly engaged in hobbies?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:
Currently active in religious/spiritual practices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formerly active in religious/spiritual practices?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Living Situation:	
Housing adequate	
Homeless	
Housing overcrowded	
Housing dangerous/ deteriorating	
Living with parents/ other family	
Living companions dysfunctional	

Social Support System:	
Supportive network	
Few friends	
Substance-use-based friends	
No friends	
Distant from family of origin	

Military History:	
Never in military	
Served in military-no incident	
Served in military-incident	

Employment:	
Employed and satisfied	
Employed but dissatisfied	
Unemployment	
Coworker conflicts	
Supervisor conflicts	
Unstable work history	
Disabled: _____	

Financial Situation:	
Relationship conflict over finances	
Large indebtedness	
Poverty or below-poverty income	
Bankruptcy	
Gambling habit/impulsive spending	

Sexual History:	
Gender Identity: (circle one)	
Woman Man Bi-gendered	
Orientation: (circle one)	
Heterosexual Homosexual Bisexual	
Currently sexually active <input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently sexually satisfied <input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently sexually dissatisfied <input type="checkbox"/> Yes <input type="checkbox"/> No	
First sex experience (age): _____	
First pregnancy/fatherhood (age): _____	
Promiscuity (age): _____ to _____	

Legal History:	
No legal problems	
Currently on parole/probation	
Arrest(s) not substance-related	
Arrest(s) substance-related	
Court ordered this treatment	
Jail/prison _____ time(s)	
Total time served:	
Describe last legal difficulty:	

Social Interactions:	
I enjoy my friends	
I find it hard to make friends	
I don't want to have friends	
I isolate myself	
I am very shy	
I am always angry at my friends	
People tell me I'm controlling	
People don't like me	