

LISTENING EAR CLINIC & CONSULTANCY PTE LTD PSYCHOTHERAPY ASSESSMENT CHECKLIST

PERSONAL DATA

Name _____ IC NO _____ Date _____
 Address _____ Age _____ DOB ____/____/____ Sex M F TG
 _____ Home Phone (____) _____
 _____ Occupation _____
 _____ Mobile Phone (____) _____
 Highest Education _____ Marital Status _____ No. of Children _____ Ages _____
 Person to contact in an emergency _____ Phone (____) _____
 Address _____ Relation to you _____

MAIN PROBLEMS: Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1	2	3	4	5	6	7	8	9	10	
Not a Problem	Mild Problem	Moderate Problem	Severe Problem	Couldn't be worse						RATING
1. _____										_____
2. _____										_____
3. _____										_____

Briefly describe what motivated you to seek therapy at this time and rate how motivated are you to work on your problems (0- Motivation, 10- Highly Motivated) and the **challenges you face in remaining motivated:** _____

(Please use the back of this page or an additional sheet of paper if you need extra space for answers)

(Axis III) MEDICAL PROBLEMS: Do you have any serious medical conditions? (If yes, please describe)..... No Yes

Problems with: Headaches ___ Indigestion ___ Diarrhea ___ Constipation ___ Circulation ___ Shortness of Breath ___ Frequent Urination ___
 Body Aches/ Pain ___ Menstrual problems ___ **How would you rate your overall health?** Excellent ___ Good ___ Fair ___ Poor ___

Please list any medications you are taking: _____

In Past Year, how many: Visits to doctor ___ Sick days ___ Cigarettes-day ___ Alcoholic drinks/day ___ Psychotherapy sessions,ever ___

Number of family members with: Alcohol/drug problems ___ Psychiatric problems (e.g., depression, psychosis) _____

(Axis IV) CURRENT STRESSFUL EVENTS: Legal ___ Financial ___ Family problems ___ Family Illness ___

Other _____ **Are you in an abusive relationship?** No ___ Somewhat ___ Yes ___

Recent losses (jobs, relationships, or difficult changes) _____

Axis V: Self -Report of Assessment of Functioning

DAILY FUNCTIONING: Please give a rough estimate of how many <u>hours per day</u> you spend doing the following in a typical day:	LIFESPAN FUNCTIONING: Please check the best and worst times of your life:			
	<u>Age</u>	<u>Best Times</u>	<u>Average times</u>	<u>Worst Times</u>
Working in your primary job	0-5	_____	_____	_____
Parenting/Caretaking of others	6-12	_____	_____	_____
Doing household chores, cooking, marketing, bills etc	13-19	_____	_____	_____
TV, Movies	20-29	_____	_____	_____
Physical recreation or exercise of some kind	30-39	_____	_____	_____
Hobbies (crafts, games, music, dancing, reading, etc.)	40-49	_____	_____	_____
Social activity with friends, family	50-59	_____	_____	_____
Religious, charity, spiritual or inspirational activities	60-69	_____	_____	_____
Quiet, non-productive, or relaxing time	70-79+	_____	_____	_____
Average number of hours of sleep <u>per night</u>				

WORST TIME IN LIFE (Please briefly describe).

 Who helped you through it? _____
 Are there things that cause you to feel ashamed or that would be difficult to talk about? (No need to specify) No Yes

BEST TIME IN LIFE (Please briefly describe) _____

 _____ Was there someone to share it with? Yes No
 Do you have a close friend who is supportive and someone you can confide in during difficult times?.....Yes No
 What have you done that you are **MOST PROUD OF**? _____

 What are your **STRENGTHS** (How do you cope) when times are hard? _____

Do you feel you are a person of worth at least on an equal basis with others? Very Much Much Somewhat A little No
How much enjoyment or pleasure are you currently getting out of living? Very Much Much Moderate A little None

(Axis V) SELF-ASSESSMENT OF FUNCTIONING: Please rate (from 1-10) how well you feel you are currently functioning in each of the three areas listed below, according the following scale:

10 ----- 9 ----- 8 ----- 7 ----- 6 ----- 5 ----- 4 ----- 3 ----- 2 ----- 1

Excellent Functioning Mild difficulty Moderate difficulty Severe Difficulty Barely able to function

1. General Mood (Depression, Anxiety, etc.) _____ **2. Social Relationships?** _____ **3. Daily work or school?** _____