CLIENT CLINICAL INFORMATION

Below is a list of concerns people sometimes have. Consider each one and decide how much each one has bothered you or has been a problem for you during the past month:

	NONE 1	2	SOME 3	4	A LOT 5
Job related concerns					
Educational concerns					
Relationship concerns					
Health concerns					
Sexual concerns					
Behavioral concerns					
Financial concerns					
Spiritual concerns					
Identity concerns					
Parenting concerns					
Legal concerns					
Family concerns					
Difficulty sleeping					
Poor judgement					
Concentration problems					
Substance abuse					
Impulsive behavior					
Self-control problems					
Mood swings					
Lack of friends					
Self-esteem issues					
Grief, loss, or mourning					
Problems with trust					
Violent/aggressive behavior					
Problems making decisions					
Memory problems					
Confusion					

	NONE 1	2	SOME 3	4	A LOT 5
Headaches					
Stomach problems					
Chronic pain					
Anxiety, nervousness					
Preoccupation with thoughts					
Chronic worry					
Fear or phobia(s)					
Difficulty relaxing					
Panic attacks					
Perfectionistic personality					
Nightmares					
Intrusive thoughts					
Feeling depressed					
Feeling overwhelmed					
Irritability					
Lack of enjoyment					
Feeling lonely					
Feeling isolated/withdrawn					
Loss of energy					
Poor appetite					
Overeating					
Lack of sexual interest					
Suicidal thoughts					
Weight gain					
Weight loss					
Feeling hopeless					
Poor motivation					

Do YOU have a history of...

Substance abuse?	Yes	No
Abuse or trauma?	Yes	No
Criminal behavior?	Yes	No
Seizure?	Yes	No
Psychiatric hospitalization?	Yes	No
Suicide attempt?	Yes	No
Educational or learning problems?	Yes	No
Threatening or harming others?	Yes	No

Is there a FAMILY history of...

Mental illness?	Yes	No
Substance abuse?	Yes	No
Domestic violence or abuse?	Yes	No

How often do you...

Smoke cigarettes (# packs/day) _____

Drink alcohol (# drinks/week) _____

Smoke marijuana (# times/mo.) _____

Use other drugs (# times/mo.) _____

Who is your primary care physician? _____

Please list any medications (& dosages) you are taking: _____

_____

_____

Please list any chronic or serious medical problems: _____

_____

Please list any prior counseling experiences:

Name of agency or counselor: *Dates of service:* *Reason for counseling:*

_____

_____

_____