

Client Name: _____

Birthdate: _____

We value your input and feel that it is important for you to be an active part of your services, or that of your child. Listed below are a number of categories in which people commonly find some difficulties. Please, indicate how you or your child is affected by circling the appropriate number for each category. Circle one number for each item.

Not a Problem	Slight Problem	Moderate Problem	Serious Problem	Severe Problem
1	2	3	4	5

I. Your Physical Functions

Sleep Pattern	1	2	3	4	5
Eating Pattern	1	2	3	4	5
Bladder Control	1	2	3	4	5
Bowel Control	1	2	3	4	5
Seizures or Convulsions	1	2	3	4	5
Speech (stutter or stammer)	1	2	3	4	5
Weight Problem	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Body Image	1	2	3	4	5
Other _____	1	2	3	4	5

II. Your Experience at Work / School

General Performance	1	2	3	4	5
General Satisfaction	1	2	3	4	5
Lateness	1	2	3	4	5
Absenteeism	1	2	3	4	5
Negative Feelings about Work / School	1	2	3	4	5
Work/Family balance	1	2	3	4	5
Relating to Supervisors/ Teachers	1	2	3	4	5
Relating to Co-Workers/Peers	1	2	3	4	5
Relating to Supervisees/ Younger Children	1	2	3	4	5
Other _____	1	2	3	4	5

III. Your Feelings & Moods

Depression (sadness)	1	2	3	4	5
Euphoria	1	2	3	4	5
Sudden Changes in Mood for No Apparent Reason	1	2	3	4	5
Anxiety (nervousness)	1	2	3	4	5
Lack of Energy	1	2	3	4	5
Feeling Angry	1	2	3	4	5
Not Liking Self	1	2	3	4	5
Not Liking Others	1	2	3	4	5
Difficulty with Daily Routine	1	2	3	4	5
Letting Others take advantage of You	1	2	3	4	5

IV. Your Behavior

Hyperactivity (can't sit still)	1	2	3	4	5
Lethargic (difficulty motivating self)	1	2	3	4	5
Repeating Certain Acts Again & Again	1	2	3	4	5
Physically Abusing Others	1	2	3	4	5
Lying	1	2	3	4	5
Stealing	1	2	3	4	5
Social Withdrawal	1	2	3	4	5
Dependent on others	1	2	3	4	5
Suspicious of others people's motives	1	2	3	4	5
Hostile Towards Others	1	2	3	4	5
Difficulty Setting Limits	1	2	3	4	5
Easily Agitated	1	2	3	4	5

V. Your Inner thoughts & ideas

Thoughts of hurting yourself	1	2	3	4	5
Having unwanted thoughts, over & over	1	2	3	4	5
Worrying about your health	1	2	3	4	5
Believing you are less than others	1	2	3	4	5
Believing you are better than others	1	2	3	4	5
Seeing things without apparent cause	1	2	3	4	5
Hearing things without apparent cause	1	2	3	4	5
Experiencing Confusion	1	2	3	4	5
Memory Problems	1	2	3	4	5
Isolate or avoid people	1	2	3	4	5

VI. Your Alcohol or Drug Use:

Circle the response that best answers:

Have you ever been concerned about your drug or alcohol use?	YES	NO	RARELY
Have others ever expressed concern about your drug or alcohol use?	YES	NO	RARELY
Do you ever drink or use drugs alone?	YES	NO	RARELY
Do you use alcohol or drugs to manage mood or handle problems?	YES	NO	RARELY
Do you consider yourself a casual or social drug user?	YES	NO	RARELY
Have you abused prescription drugs?	YES	NO	RARELY

Have you experienced any of the following?

a) Drinking/drugging more than you intended?	YES	NO	RARELY
b) Blacking out (loss of memory) after heavy drinking/drugging?	YES	NO	RARELY
c) Find yourself thinking about or planning your next drink or drug use?	YES	NO	RARELY
d) Had any legal problems related to drinking or drug use?	YES	NO	RARELY
e) Felt guilty after a period of alcohol or drug use?	YES	NO	RARELY
f) Becoming angry or agitated after drinking Liquor?	YES	NO	RARELY
g) Switching from Liquor to beer or wine in order to control alcohol use?	YES	NO	RARELY
h) Paranoid after using Marijuana?	YES	NO	RARELY
i) Used a drug without knowing what you were taking?	YES	NO	RARELY
j) Used alcohol/drugs before going to an event?	YES	NO	RARELY
k) Lied about your alcohol/drug use?	YES	NO	RARELY
l) Abused over the counter medications?	YES	NO	RARELY

Have you ever been in treatment for Alcohol or Drug Use?

YES NO

How often do you use alcohol/drugs?

___ 1-2x daily ___ 1-2x weekly ___ 1-2xmonthly ___ Less than 1x/month

Longest period of Sobriety/Clean Time _____

VII. Compulsive Behavior

Do you smoke? How much do you smoke? _____	YES	NO	RARELY
Have you used food to manage feelings of anger, sadness or loss?	YES	NO	RARELY
Do you have a history of losing and gaining weight?	YES	NO	RARELY
How much time weekly do you spend watching television? _____ hrs.			
How much time weekly do you spend being physically active? _____ Hrs			
Have you had financial problems due to compulsive spending?	YES	NO	RARELY
Have you impulsively bought items to feel good?	YES	NO	RARELY
Has anyone ever expressed concern about your gambling?	YES	NO	RARELY
Has anyone ever expressed concern about the way you spend money?	YES	NO	RARELY
Has anyone ever expressed concern about the # of hours that you work?	YES	NO	RARELY
Have you ever cut yourself to relieve intense feelings?	YES	NO	RARELY
Has anyone ever complained about your use of pornography?	YES	NO	RARELY
Have you ever felt concerned about compulsive Internet sex, phone sex or Sexual acting out?	YES	NO	RARELY
Have you ignored your own needs because of a relationship?	YES	NO	RARELY
Have you ignored the needs of your children because of a relationship?	YES	NO	RARELY

VIII. Spirituality

Are you involved in any recovery program?	YES	NO	
Do you have any affiliation with a church, temple, synagogue, or mosque? Name of Religious Institution (Optional) _____	YES	NO	
Do you attend religious services?	YES	NO	RARELY
Do you engage in any other spiritual practice?	YES	NO	RARELY

What do you do to relax? _____

What do you enjoy doing in your leisure time? _____

Signature of Client or Parent/Guardian if Client is a minor

Date

Reviewed with Therapist

Date