

CLIENT CHECKLIST

To assist your therapist make the best use of your time today, we ask that you take a few minutes to complete the questionnaire below. Thank you.

Main Areas of Concern You Would Like Addressed in Therapy

<input type="checkbox"/> Anxious feelings/worried	<input type="checkbox"/> Relationship Difficulties	<input type="checkbox"/> Problems adjusting to a new culture
<input type="checkbox"/> Adjusting to _____	<input type="checkbox"/> Restless (trouble sitting still)	<input type="checkbox"/> Sexual Issues
<input type="checkbox"/> Anger issues	<input type="checkbox"/> Feeling depressed	<input type="checkbox"/> Emotional, physical, or sexual abuse as a child
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Legal issues	<input type="checkbox"/> Emotional, physical, or sexual abuse as an adult
<input type="checkbox"/> Sleep difficulties	<input type="checkbox"/> Drug problem	<input type="checkbox"/> Stress overload
<input type="checkbox"/> Suicide thoughts	<input type="checkbox"/> Alcohol problem	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Suicide attempt	<input type="checkbox"/> Work-related stress	<input type="checkbox"/> Housing concerns
<input type="checkbox"/> Traumatic incident	<input type="checkbox"/> Fear of losing control	<input type="checkbox"/> Obsessive/compulsive disorder
<input type="checkbox"/> Financial distress	<input type="checkbox"/> Eating disorder	
Comments:		

Please check all the problems/symptoms which you have experienced in the last six (6) months.

<input type="checkbox"/> Sweating or cold clammy hands	<input type="checkbox"/> Depressed mood
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Difficulty concentrating (mind goes blank) when nervous	<input type="checkbox"/> Decreased appetite
<input type="checkbox"/> Irritable	<input type="checkbox"/> Reduced sexual interest
<input type="checkbox"/> Feelings of excessive worry	<input type="checkbox"/> Recurrent thoughts of death or dying
<input type="checkbox"/> Unrealistic worry	<input type="checkbox"/> Loss of interest or pleasure
<input type="checkbox"/> Unwanted thought you can't control	<input type="checkbox"/> Feelings of hopelessness
<input type="checkbox"/> Repetitive thoughts (i.e., counting, repeating words silently)	<input type="checkbox"/> Fatigue or low energy level
<input type="checkbox"/> Repetitive behaviors done to reduce the stress of unwanted thoughts	<input type="checkbox"/> Feeling guilty or worthless
<input type="checkbox"/> Repetitive actions (i.e., hand washing, organizing, checking)	<input type="checkbox"/> Decreased need for sleep
<input type="checkbox"/> Needing everything to be perfect	<input type="checkbox"/> Feeling "on top of the world" any special reason
<input type="checkbox"/> Being more talkative than usual (pressure to keep talking)	<input type="checkbox"/> Eating in large amounts or more than intended

<input type="checkbox"/>	Being distractible (by unimportant or irrelevant things)	<input type="checkbox"/>	Recurrent episodes of binge eating
<input type="checkbox"/>	Being hyperactive, agitated, or “speeded up”	<input type="checkbox"/>	Feeling a lack of control during periods of binge eating
<input type="checkbox"/>	Being impulsive (overspending, sexual sprees, or reckless driving)	<input type="checkbox"/>	Significant concern with body shape or weight
<input type="checkbox"/>	Knowing special secrets which no one else believes	<input type="checkbox"/>	“Feeling fat” regardless of actual body weight
<input type="checkbox"/>	Having someone else read my mind	<input type="checkbox"/>	Intense fear of gaining weight or becoming fat
<input type="checkbox"/>	Having someone else read my mind or tamper my thoughts	<input type="checkbox"/>	Self-induced vomiting or laxatives to prevent weight gain
<input type="checkbox"/>	Time loss	<input type="checkbox"/>	Concern over something that occurred within the last 6 months
<input type="checkbox"/>	Self-Injuring Behaviors: <input type="checkbox"/> Cutting <input type="checkbox"/> Burning <input type="checkbox"/> Carving <input type="checkbox"/> Pulling Hair	<input type="checkbox"/>	Being really upset about something that has happened in the past 6 months
Comments: 			