Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

(cont.)

FORM 29. Adult checklist of concerns (p. 1 of 2).

- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns . . . ")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

- ❑ _____
- ❑ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

Client Information Form 2

***Note:* If you were a patient here before, please fill in only the information that has changed.**

A. Identification

Name: _____ Date: _____

B. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

(cont.)

FORM 24. Client clinical information form (p. 1 of 4).

D. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults present: _____

3. Your parents' physical health problems, drug or alocohol use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

E. Abuse history: ❑ I was not abused in any way. ❑ I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

F. Present relationships

1. How do you get along with your present spouse or partner? _____

2. How do you get along with your children? _____

(cont.)

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

G. Chemical use

1. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes
2. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes
3. Have you ever felt guilty about your drinking? ❑ No ❑ Yes
4. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average? _____
6. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? _____
7. How much tobacco do you smoke or chew each week? _____
8. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when? _____
9. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

   _____

   _____

   Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____

   _____

   _____

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes If yes, please explain:

   _____

   _____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain:

   _____

   _____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes If yes, please explain: _____

   _____

   _____

(cont.)

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = federal, S = state, Co = county, Ci = city. Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution).

Date	Charge	Jurisdiction (F, S, C, Ci)	Sentence (AR, I, Pr, Pa)	Probation/parole officer's name	Your attorney's name

5. Your current attorney's name: ________________________ Phone: ____________
6. Are there any other legal involvements I should know about? ________________________

____

____

I. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

____

____

____

____

Please do not write below this line.

— —

J. Follow-up by clinician

Based on the responses above and on ❑ interview data ❑ records I reviewed ❑ other information
I have requested the client to complete and/or I have completed the following forms:

❑ Chemical use survey

❑ Suicide risk assessment summary and recommendations

❑ Mental status evaluation report

❑ Other: ____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

(cont.)

FORM 25. Brief health information form (p. 1 of 3).

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get? _____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____

(cont.)

3. Do you try to restrict your eating in any way? How? Why? _____

_____

_____

4. Do you have any problems getting enough sleep? _____

_____

_____

E. For women only

1. At what age did you start to menstruate (get your period): _____
2. Menstrual period experiences:
   a. How regular are they? _____
   b. How long do they last? _____
   c. How much pain do you have? _____
   d. How heavy are your periods? _____
   e. Other experiences during period? _____
3. Please list all of your pregnancies:

	What happened with this pregnancy?			
Your age	Miscarriage	Abortion	Child born	Problems?
1.				
2.				
3.				
4.				
5.				
6.				

4. Menopause:
   a. If your menopause has started, at what age did it start? _____
   b. What signs or symptoms have you had? _____

_____

F. Other

Have you ever injected drugs? ❑ Yes ❑ No Ever shared needles? ❑ Yes ❑ No

Have you had HIV testing in the last 6 months? ❑ Yes ❑ No If yes, results: _____

Are there any other medical or physical problems you are concerned about? _____

_____

_____

_____

_____

Note: Significant aspects of family medical history should be recorded on "Client Information Form 2."