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

(form)
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:

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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.)
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 alcohol 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.

<table>
<thead>
<tr>
<th>Your age</th>
<th>Kind of abuse</th>
<th>By whom?</th>
<th>Effects on you?</th>
<th>Whom did you tell?</th>
<th>Consequences of telling?</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Names</th>
<th>Good parts of relationship</th>
<th>Bad parts of relationship</th>
</tr>
</thead>
</table>

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).

<table>
<thead>
<tr>
<th>Date</th>
<th>Charge</th>
<th>Jurisdiction (F, S, C, Ci)</th>
<th>Sentence (AR, I, Pr, Pa)</th>
<th>Probation/parole officer’s name</th>
<th>Your attorney’s name</th>
</tr>
</thead>
</table>

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: ________________________________

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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.)

<table>
<thead>
<tr>
<th>Age</th>
<th>Illness/diagnosis</th>
<th>Treatment received</th>
<th>Treated by</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

2. Describe any allergies you have.

<table>
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<tr>
<th>To what?</th>
<th>Reaction you have</th>
<th>Allergy medications you take</th>
</tr>
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<tbody>
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</table>

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.

<table>
<thead>
<tr>
<th>Medication/drug</th>
<th>Dose (how much?)</th>
<th>Taken for</th>
<th>Prescribed and supervised by</th>
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4. Have you done any kinds of work where you were exposed to toxic chemicals?

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<thead>
<tr>
<th>Date</th>
<th>Kinds of chemicals</th>
<th>Kind of work</th>
<th>Effects</th>
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C. Medical caregivers

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

<table>
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<tr>
<th>Name</th>
<th>Specialty</th>
<th>Address</th>
<th>Phone #</th>
<th>Date of last visit</th>
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</table>

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

<table>
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<tr>
<th>Name</th>
<th>Specialty</th>
<th>Address</th>
<th>Phone #</th>
<th>Date of last visit</th>
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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:

<table>
<thead>
<tr>
<th>Your age</th>
<th>What happened with this pregnancy?</th>
<th>Mi miscarriage</th>
<th>Abortion</th>
<th>Child born</th>
<th>Problems?</th>
</tr>
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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.”