**General Information:**

Date:_____

Name of
Client(s):_____

Address:_____
_____

Home Phone:_____

Cell Phone(s):_____

Email Address(es):_____

Emergency Contact:_____

Client 1:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Marital Status:_____ Years in Relationship:_____

Previous Marriages:_____

Names and Ages of Children:_____
_____

Client 2:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Marital Status:_____ Years in Relationship:_____

Previous Marriages:_____

Names and Ages of Children:_____
_____

**Problem Checklist**

Rate the following areas in which problems currently exist for EACH client

0=NONE 1=MILD 2=MODERATE 3=SERIOUS 4=SEVERE

| | | | |
|---|---|---|---|
| 0 1 2 3 4 | Constant worry | 0 1 2 3 4 | Anxious or on edge |
| 0 1 2 3 4 | Nightmares | 0 1 2 3 4 | Problem solving |
| 0 1 2 3 4 | Memory problems | 0 1 2 3 4 | Indecisiveness |
| 0 1 2 3 4 | Withdrawal from others | 0 1 2 3 4 | Episodes of panic |
| 0 1 2 3 4 | Fear of being in public | 0 1 2 3 4 | Phobias |
| 0 1 2 3 4 | Feel anxious | 0 1 2 3 4 | Trouble making friends |
| 0 1 2 3 4 | Loneliness | 0 1 2 3 4 | Unwanted/distressing thoughts |
| 0 1 2 3 4 | Repetitive behavior | 0 1 2 3 4 | Troublesome thoughts/feelings |
| | | | |
| 0 1 2 3 4 | Previous episodes of depression | 0 1 2 3 4 | Previous episodes of elation |
| 0 1 2 3 4 | Feel sad | 0 1 2 3 4 | Cry easily |
| 0 1 2 3 4 | Feel hopeless | 0 1 2 3 4 | Feel guilty |
| 0 1 2 3 4 | Feel irritable | 0 1 2 3 4 | Feel worthless |
| 0 1 2 3 4 | Think about suicide | 0 1 2 3 4 | Past suicide attempts |
| 0 1 2 3 4 | Not able to have fun | 0 1 2 3 4 | No interest in usual activities |
| 0 1 2 3 4 | Unmotivated to complete tasks | 0 1 2 3 4 | Loss of interest in sex |
| | | | |
| 0 1 2 3 4 | Sexual performance problems | 0 1 2 3 4 | Bowel disturbance |
| 0 1 2 3 4 | Chronic pain | 0 1 2 3 4 | Ongoing laxative use |
| 0 1 2 3 4 | Worry over health | 0 1 2 3 4 | Medical problems |
| 0 1 2 3 4 | Skipped menstrual periods | 0 1 2 3 4 | Confusion |
| 0 1 2 3 4 | Loss of energy | 0 1 2 3 4 | Fatigue |
| 0 1 2 3 4 | Body feels slowed down | 0 1 2 3 4 | Thoughts feel slowed down |
| 0 1 2 3 4 | Body feels sped up | 0 1 2 3 4 | Racing thoughts |
| 0 1 2 3 4 | Unhappy with weight | 0 1 2 3 4 | Recent weight loss or gain |
| 0 1 2 3 4 | Binge eating | 0 1 2 3 4 | Intentional vomiting |
| 0 1 2 3 4 | Trouble falling asleep | 0 1 2 3 4 | Sleeping too much |
| 0 1 2 3 4 | Trouble staying asleep | 0 1 2 3 4 | Waking up early |
| | | | |
| 0 1 2 3 4 | Hear voices | 0 1 2 3 4 | Paranoid thoughts |
| 0 1 2 3 4 | See things that others don’t see | 0 1 2 3 4 | Strange thoughts |
| 0 1 2 3 4 | Fits of rage | 0 1 2 3 4 | Think about hurting someone |
| 0 1 2 3 4 | Poor self control | 0 1 2 3 4 | Work problems |
| 0 1 2 3 4 | Relationship problems | 0 1 2 3 4 | Problems with food |
| 0 1 2 3 4 | Problems with money | 0 1 2 3 4 | Problems at home |
| 0 1 2 3 4 | Legal problems | 0 1 2 3 4 | Cutting/hurting self |

Any areas of concern not mentioned above?_____