



Client name: \_\_\_\_\_

Client ID#: \_\_\_\_\_

## Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor.

✓  
( your concerns)

I AM EXPERIENCING...	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
I AM FEELING...	Never	Seldom	Often	Always	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE...	Never	Seldom	Often	Always	For how long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE...	Never	Seldom	Often	Always	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					



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I HAVE...	Never	Seldom	Often	Always	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING....	Never	Seldom	Often	Daily	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES...	Never	Seldom	Often	Always	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I HAVE...	Never	Seldom	Often	Always	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
EMPLOYMENT & SELF-CARE	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

**PERSONAL AND FAMILY HISTORY**

Have you or a close relative ever been hospitalized for a psychiatric illness?  Yes  No Does anyone in your family have a mental illness?  Yes  No

Has anyone in your family every attempted or committed suicide?  Yes  No Does

anyone in your family have a substance abuse problem?  Yes  No Have you ever been arrested?  Yes  No

If "yes" to any of the above, please briefly explain: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

