Living Life Counseling

CLIENT ASSESSMENT AND EVALUATION FORM

Client Name: _____ Date: _____

Have any family members (spouse, parents, grandparents, siblings, aunts, uncles, cousins, and/or child(ren) experienced any of the following behaviors)?

BEHAVIORS	YES	NO	PERSON(S)
Alcoholism			
Drug Abuse			
Depression			
Bi-polar			
Anxiety			
Panic Attacks			
Schizophrenia			
Suicide Ideation/Attempts			
Homicidal Behavior			
Divorce/Infidelity			
Domestic Violence			
Sexual Abuse/Incest			
Child Abuse/Neglect			
Anorexia (self starvation)			
Bulimia (bingeing/purging)			
ADD/ADHD			
Learning Disabilities			
Dementia/Alzheimer's			
Excessive Pornography			
Compulsive Gambling			
Financial Problems			

EVALUATION FOR DEPRESSION

Within the last two (2) weeks have you experienced any of the following? (Please check all that apply):

☐ Sadness/tearful
☐ Crying Spells
☐ Feelings of worthlessness/self hate
☐ Poor concentration
☐ Difficulty making decisions
☐ Restlessness
☐ Fatigue/low energy
☐ Poor sleep/insomnia
☐ Significant weight gain (>5%)
☐ Eating more than usual
☐ Significant Weight loss (<5%)
☐ Eating more than usual
☐ Significant weight loss
☐ Eating less than usual
☐ Postpartum symptoms
☐ Thoughts of harming yourself
☐ Thoughts of harming others
☐ Cutting self to alleviate emotional pain
☐ Current or past suicide attempts
☐ Current suicide plan

EVALUATION FOR MANIC EPISODES

During your life time have you ever experienced any of the symptoms listed below for at least a week or more? (please check all that apply)

☐ A long period of feeling "high" or an overly happy or outgoing mood
☐ Extremely irritable mood, agitation, feeling "jumpy" or "wired"
☐ Talking faster than usual; jumping from one idea to another; having racing thoughts
☐ Being easily distracted
☐ Sleeping very little
☐ Having an unrealistic belief in one's abilities
☐ Behaving impulsively; engaging in high risk behaviors ie spending sprees, gambling, sex, etc.

SLEEP HABITS

Have you experienced any of the symptoms listed below within the last two (2) weeks? (Please check all that apply)

☐ Difficulty falling asleep
☐ Typical time asleep

☐ Difficulty sustaining sleep
☐ Early morning awakening
☐ Excessive sleep
☐ Decreased need for sleep
☐ Daytime napping
☐ Typical time awake
☐ Recent changes in sleep
☐ Snoring/ C-Pap machine
☐ Feeling sleep deprived during the day
☐ Nightmares

EATING HABITS

Have you experienced any of the symptoms listed below? (Please check all that apply)

☐ Negative body image
☐ Anorexia (self starvation)
☐ Bulimia (bingeing/purging)
☐ Use of laxatives, diet pills, diuretics
☐ Excessive eating
☐ Significant appetite decrease (>5%)
☐ Significant appetite increase (>5%)
☐ Feelings of loss of control when eating

ANXIETY

Have you experienced any of the symptoms listed below within the last SIX (6) months more days than not? (please check all that apply)

☐ Constant worrying/obsessing about concerns
☐ Restlessness and feeling "keyed up" or on edge
☐ Trembling; feeling twitchy/easily startled
☐ Difficulty concentrating or mind going blank
☐ Irritability
☐ Muscle tension or muscle aches
☐ Fatigue
☐ Trouble sleeping

Check all the symptoms that develop abruptly and peak with 10 minutes? (Please check all that apply)

☐ Sweating, nausea or diarrhea
☐ Shortness of breath
☐ Rapid heartbeat
☐ Chest pain or discomfort
☐ Chills or hot flashes
☐ Numbness or tingling sensation
☐ Fear of losing control or going crazy
☐ Feeling dizzy, lightheaded or faint

AGORAPHOBIA

Have you experienced any of the symptoms listed below (Please check all that apply)

☐ Fear of leaving home

☐ Fear of traveling in a car

☐ Fear of being in a crowd

☐ Fear of standing in a line

☐ Fear of elevators

OBSESSIVE COMPULSIVE BEHAVIOR (OCD)

Have you experienced any of the symptoms listed below? (Please check all that apply)

THOUGHTS

☐ Fear of being contaminated by germs or dirt or contaminating others

☐ Fear of causing harm to yourself or others

☐ Intrusive sexually explicit or violent thoughts or images

☐ Excessive focus on religious or moral ideas

☐ Fear of losing or not having things you might need

☐ Order and symmetry: the idea that everything must line up "just right"

☐ Superstitious; excessive attention to something considered lucky or unlucky

BEHAVIORS

☐ Superstitious; excessive attention to something considered lucky or unlucky

☐ Excessive double-checking of things, such as locks, appliances and switches

☐ Repeatedly checking in on loved ones to make sure they're safe

☐ Counting, tapping, repeating certain words, or doing other senseless things to reduce anxiety

☐ Spending a lot of time washing or cleaning

☐ Ordering, evening out or arranging things "just so"

☐ Praying excessively or engaging in rituals triggered by religious fear

☐ Accumulating "junk" old papers, magazines, empty cartons, other unneeded items

POST TRAUMATIC STRESS BEHAVIOR (PTSD)

Have you experienced any of the symptoms listed below? (Please check all that apply)

☐ Reliving a traumatic event that disturbs day to day activity (battlefield experience; car accident; physical/sexual abuse

☐ Flashback episodes where the event seems to be happening again and again

☐ Repeated upsetting memories of the event

☐ Repeated nightmares of the event

☐ Strong uncomfortable reactions to situations that remind you of the event

☐ Avoiding people, places or thoughts that remind you of the event

ATTENTION AND CONCENTRATION

Have you experienced any of the symptoms listed below for at least six (6) months? (Please check all that apply)

☐ Poor listener

☐ Difficulty sustaining attention

☐ Easily distracted

☐ Avoid tasks requiring concentration

☐ Frequently make careless mistakes

☐ Frequently forgetful

☐ Frequently lose or misplace things

☐ Difficulty with planning and organization

☐ Difficulty following through on assignment

☐ Fail to finish assignments or tasks

ALCOHOL, DRUGS, PRESCRIPTION MEDICATION

Have you experienced any of the symptoms listed below during the last twelve (12) months? (Please check all that apply)

☐ Increased use to achieve desired effect

☐ Decreased use to achieve desired effect

☐ Substance used in larger amounts than initially intended

☐ Unsuccessful attempts to limit or stop usage

☐ Social, school, work, hobbies reduced/given up due to use

☐ Taken high risks while using substance

☐ Physical/emotional withdrawal when not using substances

☐ Continued use despite physical, medical or emotional problems

☐ Past or present drunk driving tickets (DUI)

☐ Past or current AA/NA meetings

☐ Past or current inpatient or outpatient counseling

SEXUAL HISTORY

Please check all that apply:

☐ Satisfied with your sexual relationship

☐ Dissatisfied with sexual relationship

☐ Preoccupied with sexual fantasies

☐ Internet pornography

☐ Compulsive masturbation

☐ Premature ejaculation

☐ Male erectile dysfunction (ED)

☐ Orgasmic difficulties

☐ Genital pain associated with intercourse

☐ High libido

☐ Low libido

☐ Past sexual abuse

ANGER MANAGEMENT

Please check all that apply

☐ Suppress your anger due to fear of rejection and/or confrontation

☐ Provoke others to get angry

☐ Explode with anger rather quickly

☐ Get angry when feeling ashamed, guilty, jealous and/or vulnerable

☐ Verbal abuse towards spouse/family/friends when angry

☐ Physical abuse towards spouse/family/friends when angry

☐ Physically hurt yourself when angry