

Outpatient Services

Adult Client Checklist – 19 Years and Older

Client Name: _____ Date: _____

PROBLEMS you are having and/or past experiences (check all that apply):
 (You will not be required to talk about these if you are uncomfortable)

Problem	How Long?	Problem	How Long?
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Drug abuse or addiction (self)	_____
<input type="checkbox"/> Legal problems	_____	<input type="checkbox"/> Alcohol abuse/addiction (self)	_____
<input type="checkbox"/> Low self-esteem	_____	<input type="checkbox"/> Anger or temper problems	_____
<input type="checkbox"/> Anxiety/Fears	_____	<input type="checkbox"/> Step-family problems	_____
<input type="checkbox"/> Eating disorder	_____	<input type="checkbox"/> Violence in family	_____
<input type="checkbox"/> Compulsive gambling	_____	<input type="checkbox"/> Sexual problems	_____
<input type="checkbox"/> Parent/Child conflict	_____	<input type="checkbox"/> Forced sexual contact	_____
<input type="checkbox"/> Marital/relationship problems	_____	<input type="checkbox"/> Death of a loved one	_____
<input type="checkbox"/> Emotional Abuse	_____	<input type="checkbox"/> Witnessed someone seriously injured or killed	_____
<input type="checkbox"/> Neglect as a child	_____	<input type="checkbox"/> Witnessed physical/sexual assault against family member or friend	_____
<input type="checkbox"/> Physical abuse	_____	<input type="checkbox"/> Alcohol/drug abuse in family	_____
<input type="checkbox"/> Threatened with weapon or feared someone would hurt you	_____	<input type="checkbox"/> Communication problems	_____
<input type="checkbox"/> Sexual abuse history (as victim)	_____	<input type="checkbox"/> Financial concerns	_____
<input type="checkbox"/> Job/school problems unemployment	_____	<input type="checkbox"/> Worries or moodiness	_____
<input type="checkbox"/> Diagnosed Hyper or ADD/ADHD	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Major losses/difficult changes	_____		

SYMPTOMS you are having lately (check all that apply):

Problem	How Long?	Problem	How Long?
<input type="checkbox"/> Intense fear or panic	_____	<input type="checkbox"/> Gaining or losing weight	_____
<input type="checkbox"/> Difficulty falling asleep	_____	<input type="checkbox"/> Loss of appetite (not hungry)	_____
<input type="checkbox"/> Waking in middle of night	_____	<input type="checkbox"/> Vomiting after eating	_____
<input type="checkbox"/> Waking up too early	_____	<input type="checkbox"/> Sick to stomach	_____
<input type="checkbox"/> Sleeping too much	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> Moody and/or crying more	_____	<input type="checkbox"/> Nightmares	_____
<input type="checkbox"/> Feeling guilty or worthless	_____	<input type="checkbox"/> Flashbacks	_____
<input type="checkbox"/> Fatigue or low energy	_____	<input type="checkbox"/> Constipation	_____
<input type="checkbox"/> Hyper- too much energy	_____	<input type="checkbox"/> Diarrhea	_____
<input type="checkbox"/> Mind racing	_____	<input type="checkbox"/> Difficulty concentrating	_____
<input type="checkbox"/> Loss of interest in things	_____	<input type="checkbox"/> Problems remembering things	_____
<input type="checkbox"/> Disturbing thoughts	_____	<input type="checkbox"/> Loss of time	_____
<input type="checkbox"/> Suicidal thoughts	_____	<input type="checkbox"/> Withdrawing from others	_____
<input type="checkbox"/> Harms self	_____	<input type="checkbox"/> Repeated actions (can't stop)	_____
<input type="checkbox"/> Harms others	_____	<input type="checkbox"/> Anger problems	_____