

Inner Nourish Counseling, LLC
Isabel Perez, MA, LPC
Client Checklist of Concerns

CURRENT SYMPTOM CHECKLIST (using a check mark, rate the intensity of symptoms currently present)

- None** = This symptom not present at this time.
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate = Significant impact on quality of life and/or day-to-day functioning.
Severe = Profound impact on quality of life and/or day-to-day functioning.

SYMPTOM	NONE	MILD	MODERATE	SEVERE	SYMPTOM	NONE	MILD	MODERATE	SEVERE
Depressed Mood					Hallucinations: visual				
Appetite disturbance					Hallucinations: audio				
Sleep disturbance					Dissociative states				
Fatigue/low energy					Significant weight gain/loss				
Poor concentration					Anorexia				
Worthlessness					Binge eating				
Hopelessness					Purging/vomiting				
Mood swings					Laxative/diuretic use				
Emotionality/labile					Substance abuse				
Elevated mood					Somatic complaints				
Agitation					Sexual dysfunction				
Anger/Irritability					Self-mutilation				
Social isolation					Guilt				
Conduct problems					Grief				
Oppositional behavior					Domestic Violence (V)*				
Aggressive behaviors					Domestic Violence (P)*				
Hyperactivity					Emotional trauma (V)*				
Generalized anxiety					Emotional trauma (P)*				
Panic attacks					Physical trauma (V)*				
Phobias					Physical trauma (P)*				
Obsessions					Sexual trauma (V)				
Compulsions					Sexual trauma (P)*				
Delusions					Suicidal Thoughts				

* V=victim P=perpetrator

MEDICAL HISTORY: (check all that apply)

Describe current physical health: " Excellent " Good " Fair " Poor

Allergies:		Diabetes		Lupus	
Alzheimer's disease/dementia		Fibromyalgia/Epstein-Barr		Migraines	
Arthritis (osteo)		Gastro-intestinal difficulties		PMS/PMDD	
Arthritis (rheumatoid)		Head injury		Stroke	
Cancer (type):		Heart disease		Thyroid problems	
Chronic pain		High blood pressure		Eating Disorder, by history	
Other serious health problems:					

Comments: **(Please note any current medications that you are taking)**

FAMILY HISTORY: (mark all that apply in each box)

Family of Origin:

During childhood:	Present for entire childhood	Present for part of childhood	Not present at all
Mother			
Father			
Stepmother			
Stepfather			
Brother(s)			
Sister(s)			
Grandparents			
Other (specify)			

Parents Current Status:	
Married to each other	
Separated for ___ years	
Divorced for ___ years	
Mother remarried ___ times	
Father remarried ___ times	
Mother involved with someone	
Father involved with someone	
Mother deceased for ___ years at age ____	
Father deceased for ___ years at age ____	

Describe Childhood Family Experience:	
Normal home environment	
Chaotic home environment	
Experienced neglect	
Witnessed physical/verbal/sexual abuse toward others	
Experienced physical/verbal/sexual abuse from others	

(Minors only) Describe Parents:		
	Mother/Step-Mother/Guardian	Father/Step-Father/Guardian
Name		
Education		
General Health		
Occupation		

RELATIONSHIP HISTORY:

Current Relationship Status	
single	
living together ___ mos/yrs	
engaged ___ mos/yrs	
common-law ___ mos/yrs	
married for ___ mos/yrs	
life-partnered ___ mos/yrs	
separated for ___ mos/yrs	
divorce in progress ___ mos/yrs	
divorced for ___ mos/yrs	
___ prior marriages (self)	
___ prior marriages (partner)	

Intimate Relationship	
never been in a serious, intimate relationship	
not currently in an intimate relationship	
currently in a serious, intimate relationship	
multiple intimate relationships	

Relationship Satisfaction	
very satisfied with relationship	
satisfied with relationship	
somewhat satisfied with relationship	
dissatisfied with relationship	
very dissatisfied with relationship	

CULTURAL/SPIRITUAL HISTORY:

Cultural identity: _____

Religious/spiritual identity: _____

Any cultural or religious issues that contribute to current problem? Y N Describe: _____

Activities	
Currently active in community/recreational activities?	Y N If yes, specify:
Formerly active in community/recreational activities?	Y N If yes, specify:
Currently engaging in hobbies?	Y N If yes, specify:
Formerly engaged in hobbies?	Y N If yes, specify:
Currently active in religious/spiritual practices?	Y N
Formerly active in religious/spiritual practices?	Y N

SOCIO-ECONOMIC HISTORY: (check/mark all that apply in each box)

Living Situation:	
Housing adequate	
Homeless	
Housing overcrowded	
Housing dangerous/deteriorating	
Living with parents/other family	
Living companions dysfunctional	

Social Support System:	
Supportive network	
Few friends	
Substance-use-based friends	
No friends	
Distant from family of origin	

Social Interactions:	
I enjoy my friends	
I find it hard to make friends	
I don't want to have friends	
I isolate myself	
I am very shy	
I am always angry at my friends	
People tell me I'm controlling	
People don't like me	

Employment:	
Employed and satisfied	
Employed but dissatisfied	
Unemployment	
Coworker conflicts	
Supervisor conflicts	
Unstable work history	
Disabled: _____	

Military History:	
Never in military	
Served in military- no incident	
Served in military-w/ incident	

Sexual History:	
Gender Identity: (circle one)	
Woman Man Bi-gendered	
Orientation: (circle one)	
Heterosexual Homosexual Bisexual	
Currently sexually active: __Y__N	
Currently sexually satisfied: __Y__N	

Financial Situation:	
Relationship conflict over finances	
Large indebtedness	
Poverty or below-poverty income	
Impulsive spending	
Gambling habit	

Legal History:	
No legal problems	
Currently on parole/probation	
Arrest(s) not substance-related	
Arrest(s) substance-related	
Court ordered this treatment	
Jail/prison _____ time(s)	
Total time served:	
Describe last legal difficulty:	

First sex experience -- age _____
First pregnancy/fatherhood -- age _____
Promiscuity -- age _____ to _____
Unsafe sex -- age _____ to _____

SUBSTANCE USE HISTORY: (check all that apply in each box)

Family Alcohol/Drug Abuse History			
Father		Grandparent(s)	
Mother		Stepparent/live-in	
Other _____		Sibling(s)	
		Uncle(s)/aunt(s)	
		Spouse/significant other	
		Children	

Comments: _____

Current Alcohol/Drug Use Status

Active use	Active abuse	Early partial remission	
No history of abuse	Early full remission	Sustained full remission	mos./yrs.

Comments: _____

Treatment History

No treatment	Inpt. age(s) _____	Stopped on own age(s) _____
Outpt. age(s) _____	12-step age(s) _____	Other age(s) _____
Describe: _____		

Comments: _____

Substances used (mark all that apply)

	C=current/ P=past	Age 1st use	Age last use	Frequency	Amount
Alcohol					
Caffeine					
Cocaine					
Crack cocaine					
Ecstasy					
Hallucinogens (LSD, etc.)					
Inhalants (glue, gas, etc.)					
Marijuana/pot					
Meth					
Nicotine					
PCP					
Sleeping pills					
Prescription meds					
Over-the-counter meds					
Other _____					

Consequences of substance use (check all that apply)

Binges	Overdose	Sleep disturbance	Poor judgment
Hangovers	Withdrawal symptoms	Relationship conflicts	Assaults
Blackouts	Tolerance changes	Suicidal	Arrests
Seizures	Loss of control amt. used	Sexual drive	Job loss
Other: _____			

TREATMENT GOALS: (What are they and how will you know you are done with therapy?)

