CLIENT CONCERNS

Name:____

Using the scale below, please rate the severity of any concerns that apply to you. If something does not apply to you, please leave that one blank and go to the next concern

_____ Marital stress
_____ Other family problems
_____ Problems at work/school
_____ Health problems
_____ Financial problems
_____ Legal problems
_____ Sad/depressed
_____ Loss of appetite
_____ Loss of weight
_____ Difficulty sleeping
_____ Difficulty concentrating
_____ Quick change of moods
_____ Dwelling on problems
_____ Problems with breathing
_____ Hot or cold spells
_____ Problems controlling anger or urges
_____ Feeling suicidal
_____ Feeling worthless

_______ Drawing away from people
_______ Too many drugs
_______ Too much alcohol
_______ Feel negative about the future
_______ Hard to make friends
_______ Feeling lonely
_______ Sexual problems
_______ Less energy than usual
_______ More energy than usual
_______ Very talkative
_______ Restless/can’t sit still
_______ Nervous/tense
_______ Panicky
_______ Shaky/trembling
_______ Hard to trust anyone
_______ Problems controlling my thoughts
_______ Upset stomach
_______ Sweating

_______ Light Headed/dizzy
_______ Too much worry
_______ Too many fears
_______ Feeling guilty
_______ Lack of interest/enjoyment
_______ Nightmares
_______ Feel ignored/abandoned
_______ Too much pain
_______ Confused
_______ Laugh without reason
_______ Feeling angry/frustrated
_______ Memory problems
_______ See/hear strange things
_______ Feel used by people
_______ Feel others are out to get me
_______ Watched/talked about by others
_______ Other

1 = Mildly distressing
2 = Moderate
3 = Serious
4 = Severe
5 = Very severely distressing