Client Name: _____

Date: _____

PRESNTING SITUATIONS

Please circle Y for Yes and N for No situations you are currently experiencing and circle PAST for situations you have experienced in the past.

Y	N	PAST	Headaches	Y	N	PAST	Rituals (hand-washing/checking)
Y	N	PAST	Stomach trouble				Others concerned about your drug or alcohol
Y	N	PAST	Bowel problems	Y	N	PAST	abuse
Y	N	PAST	Physical pain	Y	N	PAST	Tingling or numbness
Y	N	PAST	Take pain pills often	Y	N	PAST	Repetitive behaviors
Y	N	PAST	Frequent fatigue	Y	N	PAST	Worry a lot
Y	N	PAST	Other health problems	Y	N	PAST	Nightmares
Y	N	PAST	Poor sleep/ too little	Y	N	PAST	Frequent spacing out
Y	N	PAST	Sleep too much	Y	N	PAST	Significant time loss
Y	N	PAST	Take sleeping pills often	Y	N	PAST	Memory problems
Y	N	PAST	Depression	Y	N	PAST	Hearing voices
Y	N	PAST	Mood swings	Y	N	PAST	Hallucinations
Y	N	PAST	Low energy	Y	N	PAST	Binge eating
Y	N	PAST	Poor concentration	Y	N	PAST	Self-induced vomiting
Y	N	PAST	Difficulty focusing	Y	N	PAST	Periods of self-starving
Y	N	PAST	Trouble with decisions	Y	N	PAST	Excessive exercise
Y	N	PAST	Irritability	Y	N	PAST	Laxative overuse
Y	N	PAST	Problems with anger	Y	N	PAST	Overuse of alcohol
Y	N	PAST	Verbal abusiveness	Y	N	PAST	Alcohol induced blackouts
Y	N	PAST	Physical abusiveness	Y	N	PAST	Overuse prescription drugs
Y	N	PAST	Suicidal thoughts	Y	N	PAST	Compulsive behaviors
Y	N	PAST	Prior suicide attempts	Y	N	PAST	Spending too much money
Y	N	PAST	Thoughts of death	Y	N	PAST	Intentional self-injury
Y	N	PAST	Cry frequently	Y	N	PAST	Victim of abuse
Y	N	PAST	Poor appetite	Y	N	PAST	Impulsive decisions
Y	N	PAST	Weight loss	Y	N	PAST	Impulsive behaviors
Y	N	PAST	Weight gain	Y	N	PAST	Trouble on the job
Y	N	PAST	Excessive energy periods	Y	N	PAST	Flashbacks
Y	N	PAST	Frequent high anxiety	Y	N	PAST	Difficulty coping
Y	N	PAST	Obsessing thoughts	Y	N	PAST	Hard to function
Y	N	PAST	Panic attacks	Y	N	PAST	Sexual problems
Y	N	PAST	Fear going crazy	Y	N	PAST	Relationship problems
Y	N	PAST	Other intense fears	Y	N	PAST	Low self-esteem
Y	N	PAST	Anxiety in social setting	Y	N	PAST	Spirituality concerns
Y	N	PAST	Feel shaky frequently	Y	N	PAST	Too much stress
Y	N	PAST	Intrusive thoughts/images				
Y	N	PAST	Difficult getting along with people				

What do you hope to gain from treatment at this time, e.g., what are your most important goals?

_____

(continue on the back if necessary)