Peaceful Minds Therapy, LLC

Professional Psychotherapist

Client Checklist of Concerns

CURRENT SYMPTOM CHECKLIST:

(check mark the rate the intensity of symptoms currently present)

None (0) = This symptom is not present at this time.

Mild (1)= Impacts quality of life, but no significant impairment of day-to-day functioning.

Moderate (2)= Significant impact on quality of life and/or day-to-day functioning.

Severe (3)= Profound impact on quality of life and/or day-to-day functioning.

Symptom	0	1	2	3	Symptom	0	1	2	3
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:

Describe your 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 Problem	
Chronic pain		High blood pressure			
Other serious health problems					

Treatment History (Therapists, Doctors, Hospitalizations, diagnosis)

_____

_____

_____

List Medications currently taking:_____

Last Physical exam:_____By whom:_____

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Family History: Check all that apply

Please list Family members that have mental illness, or substance abuse_____

_____

_____

_____

If married/partnered, list name of partner, also list children both biological and step along with their ages:

_____

_____

Childhood Family Experience:	
Two parent household	
One parent household	
Experienced neglect	
Witnessed physical/verbal/sexual abuse toward others	
Experienced physical/verbal/sexual abuse from others	

Current Relationship Status:	
Single	
Living together_____months _____years	
Engaged_____months_____years	
Common law_____months_____years	
Married for_____months_____years	
Life-partnered_____months _____ years	
Separated for_____months _____ years	
Divorce in progress____months_____ years	
Divorced for_____months_____years	
_____ 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	

Activities
Currently active in community/recreational activities? ❑ Yes ❑No If yes, specify:
Formerly active in community/recreational activities? ❑ Yes ❑No If yes, specify:
Currently engaging in hobbies? ❑ Yes ❑No If yes, specify:
Formerly engaged in hobbies? ❑ Yes ❑No If yes, specify:
Currently active in religious/spiritual practices? ❑ Yes ❑No
Formerly active in religious/spiritual practices? ❑ Yes ❑No

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Cultural Identity: _____

Religious/Spiritual identity: _____

Is your spirituality/ religion important?

Any cultural or religious issues that contribute to current problem? ❑ Yes ❑No Describe: _____

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

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: _____

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

Substances Used:					
	Current/**P**ast	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 medications					
Over-the-counter medications					
Other					

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

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

What is one thing that you would **Not** change in your life:_____

_____

_____

What is the most important thing you would like to change? _____

_____

What do you expect to get out of therapy?

_____

_____

_____

Have you seen or sought out therapy before? if so what for/ and was it helpful?

_____

_____

Please list any other information that you feel is important I know:_____

_____

_____