

**ADULT SYMPTOM/PROBLEM ASSESSMENT**

**Client Name** \_\_\_\_\_

Please indicate the **PRIMARY** cause for your visit today.

- |                              |                            |                                  |                            |
|------------------------------|----------------------------|----------------------------------|----------------------------|
| ___ Depressed feelings       | ___ Grief or Loss          | ___ Relationship/family Problems | ___ Occupational Problems  |
| ___ Anxiety or worry         | ___ Abuse Issues           | ___ General Stress               | ___ Physical Health Issues |
| ___ Other emotional concerns | ___ Substance Use Concerns | ___ Self-Esteem Issues           | ___ Eating Problems        |

**How much have you been bothered by the following symptoms over the last 7 days.** (Circle *only* the ratings that apply to you)  
**Rating: 1 = mildly bothered 2 = moderately bothered 3 = severely bothered**

- |                     |       |                         |       |
|---------------------|-------|-------------------------|-------|
| Feeling sad or down | 1 2 3 | Mood Swings             | 1 2 3 |
| Loneliness          | 1 2 3 | Perfectionism           | 1 2 3 |
| Worthlessness       | 1 2 3 | Emptiness               | 1 2 3 |
| Low Self-esteem     | 1 2 3 | Anger/Temper Problems   | 1 2 3 |
| Nervousness/Worry   | 1 2 3 | Irritability            | 1 2 3 |
| Panic Feelings      | 1 2 3 | Poor Concentration      | 1 2 3 |
| Restlessness        | 1 2 3 | Cutting/Self Mutilating | 1 2 3 |
| Lack of Energy      | 1 2 3 | Feeling Overwhelmed     | 1 2 3 |
| Low Motivation      | 1 2 3 | Nightmares/flashbacks   | 1 2 3 |
| Fears or phobias    | 1 2 3 | Guilt                   | 1 2 3 |
| Suicidal thoughts   | 1 2 3 | Withdrawn/avoidant      | 1 2 3 |

**How has your life been affected by the symptoms or problem that brought you here?**

Circle your current level of impairment for *only* those issues that apply to you. 1 = slight 2 = moderate 3 = severe

**ACTIVITIES OF DAILY LIVING**

- |                     |       |
|---------------------|-------|
| Getting out of bed  | 1 2 3 |
| Sleeping            | 1 2 3 |
| Person hygiene      | 1 2 3 |
| Household chores    | 1 2 3 |
| Paying bills        | 1 2 3 |
| Opening mail        | 1 2 3 |
| Making/eating meals | 1 2 3 |
| _____               | 1 2 3 |

**OCCUPATIONAL**

- |                             |       |
|-----------------------------|-------|
| Arriving late/leaving early | 1 2 3 |
| Quality of work             | 1 2 3 |
| Not attending work          | 1 2 3 |
| Non-compliance with rules   | 1 2 3 |
| Excessive errors            | 1 2 3 |
| Impaired creativity         | 1 2 3 |
| Poor judgment               | 1 2 3 |
| Dishonest behavior          | 1 2 3 |
| Co-worker fights/arguments  | 1 2 3 |
| _____                       | 1 2 3 |

**BEHAVIORAL**

- |                            |       |
|----------------------------|-------|
| Normal Exercise up/down    | 1 2 3 |
| Self injurious behavior    | 1 2 3 |
| Appetite loss/overeating   | 1 2 3 |
| Weight gain/loss           | 1 2 3 |
| Alcohol/drug use increased | 1 2 3 |
| Increased smoking          | 1 2 3 |
| Reckless driving           | 1 2 3 |
| Increased spending         | 1 2 3 |
| Loss of enjoyment          |       |
| in fun activities          | 1 2 3 |
| Poor or non compliance     |       |
| with medications           | 1 2 3 |

**RELATIONAL/MARITAL**

- |                  |       |
|------------------|-------|
| Fights/arguments | 1 2 3 |
| Withdrawal       | 1 2 3 |
| Aggressiveness   | 1 2 3 |
| Violence         | 1 2 3 |
| Lying            | 1 2 3 |
| Sexual problems  | 1 2 3 |
| _____            | 1 2 3 |

**SOCIAL RELATIONSHIPS**

- |                             |       |
|-----------------------------|-------|
| Isolation/withdrawal        | 1 2 3 |
| Loss of relationships       | 1 2 3 |
| Discord with friends/family | 1 2 3 |
| _____                       | 1 2 3 |

**SPIRITUAL**

- |                             |       |
|-----------------------------|-------|
| Inability to pray/meditate  | 1 2 3 |
| Inability to participate in |       |
| Spiritual community         | 1 2 3 |

**PHYSICAL PROBLEMS** (Circle the level of problem you experience currently) 1 = slight 2 = moderate 3 = severe

- |           |       |                       |       |                     |       |
|-----------|-------|-----------------------|-------|---------------------|-------|
| Dizziness | 1 2 3 | Heart racing/pounding | 1 2 3 | Stomach trouble     | 1 2 3 |
| Headaches | 1 2 3 | Swallowing            | 1 2 3 | Ulcer               | 1 2 3 |
| Blackouts | 1 2 3 | Indigestion/heartburn | 1 2 3 | Thyroid             | 1 2 3 |
| Allergies | 1 2 3 | Frequent colds        | 1 2 3 | Feeling cold        | 1 2 3 |
| Back pain | 1 2 3 | Asthma                | 1 2 3 | Chest pain/pressure | 1 2 3 |

Other \_\_\_\_\_

What would you like to achieve as a result of therapy? \_\_\_\_\_

\_\_\_\_\_