*Evangelical Child and Family Agency*
*1530 N. Main St. ▪ Wheaton, IL 60187*

# Information from Client

Name: _____ Date / time of first appointment: _____

Getting to know you and your situation is an important step in the counseling process. You are the most important source of information about you and your life circumstances. Please complete this questionnaire to the best of your ability and bring it with you to your first counseling session. This information will be used by you and your therapist to develop a plan for your services. The information will be kept confidential unless you provide written permission to share it with someone else.

**The problem(s) you are experiencing:**

1. Describe the issues or problem(s) for which you are seeking counseling?

2. For how long have these problems or issues been a concern to you?

3. How have your daily activities been affected?

**Your perceptions and preferences:**

1. Describe your strengths and resources, individually and in your family?

2. Which persons do you count on most for support in your life?

3. How would you like counseling to be helpful to you?

4. What goals do you have for yourself in the next 12 months?

**You and your family members' experience with mental / emotional issues:**

1. Describe any known instances of mental or emotional problems in your family (be as specific as possible regarding relationships, dates, etc.)

2. Describe any known mental /emotional issues while you were an infant or child.

3. Describe any treatment you received for the conditions mentioned under #2.

4. What prescription medications do you currently take?

5. Check one word below that best describes your physical health:
   ____Excellent ____Good ____Poor

   Comment on reasons if you checked "poor".

   Date of last physical examination: _____

6. List any known allergies:

**Your current situation:**

1. Are you able to effectively handle the normal tasks of daily living? Yes___ No___
   If you checked "no", which tasks present the biggest challenge?

2. Are you facing any legal problems? Yes No *(circle one)*

   If you circled "yes" please briefly describe:

3. What are your interests, activities and hobbies?

4. Describe your friendships.

5. Describe your current and past use of drugs and abuse of alcohol.

6. Are you experiencing any financial problems? Yes____ No____
   If you checked "yes", please briefly describe:

7. Are you employed? Full-time or part-time, type of work, etc.

8. Describe your housing / living situation.

9. What is your level of education and your chosen vocation? Do you have any specialized training?

**Religious / Spiritual Practices:**

1. What is your religious / church affiliation?

2. How would you describe your spiritual practices in your life?

3. What do you do in your life that is especially enjoyable?

4. What are ways you handle stressful events in your life?

_____ _____

Client Signature Date

Thank you for taking the time to answer these questions. Please bring this information with you to your first counseling session. The information you provide will be kept confidential unless you provided written consent to release it.

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# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Adult

Name: _____ Age: _____ Sex: ❒ Male ❒ Female Date: _____

*If this questionnaire is completed by an informant*, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ **hours / week**

**Instructions**: the questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

| | During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several Days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling, nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 23. Using any of the following medicines ON YOUR OWN, that is without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |