Megan Rogers, MA, MSW, LCSW
Client Checklist of Concerns and Health History

CURRENT SYMPTOM CHECKLIST (using a check mark, rate the intensity of symptoms currently present)

None = This symptom not present at this time.
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate = Significant impact on quality of life and/or day-to-day functioning.
Severe = Profound impact on quality of life and/or day-to-day functioning.

SYMPTOM	NONE	MILD	MODERATE	SEVERE	SYMPTOM	NONE	MILD	MODERATE	SEVERE
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: (check all that apply)

Describe 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 problems	
Chronic pain		High blood pressure		Birth Control History (women)	
Digestion issues		Constipation, diarrhea, gas		Yeast or Urinary Infections	
Other serious health problems:					

Comments: _____

_____

CURRENT MEDICATIONS & SUPPLEMENTS: _____

FAMILY HISTORY: (mark all that apply in each box)

Family of Origin:

During childhood:	Present for entire childhood	Present for part of childhood	Not present at all
Mother			
Father			
Stepmother			
Stepfather			
Brother(s)			
Sister(s)			
Grandparents			
Other (specify)			

Parents Current Status:	
Married to each other	
Separated for ___ years	
Divorced for ___ years	
Mother remarried ___ times	
Father remarried ___ times	
Mother involved with someone	
Father involved with someone	
Mother deceased for ____ years at age ____	
Father deceased for ____ years at age ____	

Describe Childhood Family Experience:	
Normal home environment	
Chaotic home environment	
Experienced neglect	
Witnessed physical/verbal/sexual abuse toward others	
Experienced physical/verbal/sexual abuse from others	

(Minors only) Describe Parents:		
	Mother/Step-Mother/Guardian	Father/Step-Father/Guardian
Name		
Education		
General Health		
Occupation		

List your siblings in order of their birth. Next to their name, indicate their age:

_____

_____

What is your birth order? _____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____

RELATIONSHIP HISTORY:

Current Relationship Status	
single	
living together _____ mos/yrs	
engaged _____ mos/yrs	
common-law _____ mos/yrs	
married for _____ mos/yrs	
life-partnered _____ mos/yrs	
separated for _____ mos/yrs	
divorce in progress _____ mos/yrs	
divorced for _____ mos/yrs	
_____ 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	

CULTURAL/SPIRITUAL HISTORY:

Cultural identity: _____ Religious/Spiritual identity: _____

Do either of these contribute to your current issues or functioning? Please explain:

_____

Activities
Currently active in community/recreational activities? Y N If yes, specify:
Formerly active in community/recreational activities? Y N If yes, specify:
Currently engaging in hobbies? Y N If yes, specify:
Formerly engaged in hobbies? Y N If yes, specify:
Currently active in religious/spiritual practices? Y N
Formerly active in religious/spiritual practices? Y N

SOCIO-ECONOMIC HISTORY: (check/mark all that apply in each box)

Living Situation:	
Housing adequate	
Homeless	
Housing overcrowded	
Housing dangerous/deteriorating	
Living with parents/other family	
Living companions dysfunctional	

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

Financial Situation:	
Relationship conflict over finances	
Large indebtedness	
Poverty or below-poverty income	
Impulsive spending	
Gambling habit	

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

Military History:	
Never in military	
Served in military- no incident	
Served in military-w/ incident	

Legal History:	
No legal problems	
Currently on parole/probation	
Arrest(s) not substance-related	
Arrest(s) substance-related	
Court ordered this treatment	
Jail/prison _____time(s)	
Total time served:	
Describe last legal difficulty:	

Social Interactions:	
I enjoy my friends	
I find it hard to make friends	
I don't want to have friends	
I isolate myself	
I am very shy	
I am always angry at my friends	
People tell me I'm controlling	
People don't like me	

Sexual History:
Gender Identity: (circle one) Woman Man Bi-gendered
Orientation: (circle one) Heterosexual Homosexual Bisexual
Currently sexually active: ___Y ___N
Currently sexually satisfied: ___Y ___N

First sex experience -- age _____
First pregnancy/fatherhood -- age _____
Promiscuity -- age _____ to _____
Unsafe sex -- age _____ to _____

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

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

Comments: _____

_____

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: _____

_____

Treatment History					
No treatment		Inpt. age(s) _____		Stopped on own age(s) _____	
Outpt. age(s) _____		12-step age(s) _____		Other age(s)_____	
Describe:					

Comments: _____

_____

Substances used (mark all that apply)					
	C=current/ **P**=past	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 meds					
Over-the-counter meds					
Other _____					

Consequences of substance use (check all that apply)							
Binges		Overdose		Sleep disturbance		Poor judgment	
Hangovers		Withdrawal symptoms		Relationship conflicts		Assaults	
Blackouts		Tolerance changes		Suicidal		Arrests	
Seizures		Loss of control amt. used		Sexual drive		Job loss	
Other:							

Comments: _____

_____

OTHER:

Have you or your family experienced any major life changes? If so, please comment:

_____

Have you experienced any major losses in life? If so, please comment:

_____

At what point in your life did you feel best? _____

_____

How much time have you had to take off from work or school in the past year? (0-2 days; 3-14 days; more than 15 days) _____

Any healers, helpers, or therapies with which you are involved? Please list:

_____

Previous counseling, therapies, healers: Yes No If yes, please list dates and give reason:

_____

_____

What foods did you eat often as a child?

Breakfast Lunch Dinner Snacks Liquids

What's your food like these days?

Breakfast Lunch Dinner Snacks Liquids

Are you currently on a special diet or avoiding certain foods because of the way they make you feel? Details:

_____

Are there any foods you crave? Details:

_____

Approximately what percentage of your meals is home-cooked? _____

Have you had periods of eating junk food, binge eating, or dieting? List any known diet you've been on for a significant amount of time:

_____

How do you handle stress?

_____

Describe your sleep patterns. Do you fall asleep easily? Stay asleep? How many hours per night, on average?

_____

On a scale of 1 – 10 (1 is worst, 10 is best), what is your usual level of energy? _____

Will your family and/or friends be supportive of your desire to improve your mental health, health, and/or lifestyle?

Who in your family or on your healthcare team will be most supportive? _____

_____

What's the most important thing you believe you should change to improve your health?

_____

_____

Thoughts on *why* you might want to improve your health and mood? Why is this important? Please share:

_____

_____

_____

_____