Client Last Name First Name Date

Feelings:	A Little	A Lot	Comments
Sad			
Anxious			
Stressed			
Scared			
Lonely			
Guilty			
Frustrated			
Angry			
Degraded			
Problems:			
At Home			
At School			
At Work			
In my Social Arena			
Sleeping			
Eating			
Weight Gain			
Weight Loss			
Harm to Self/Others:			
I have hurt someone in the past			
I have thoughts of hurting someone			
I have thoughts of hurting myself			
Support:			
I have close friends to talk to			
I have family that is there for me			
Self Worth:			
I feel confident in my abilities to solve problems			
I feel good about myself			

List areas of concern (in order of priority):

1. _____
2. _____
3. _____

What dates have you previously been in counseling, and for how long?

_____

_____

_____

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First session date: _____

DSM-IV Diagnosis: Axis I: _____ Code: _____

Axis II: _____ Code: _____