Adult Clinical Update

Today's Date:_____

Name_____

Address:_____

Emergency Contact
Information
Name:_____ Relationship_____ Phone_____

When you have completed therapy, what would you like to be different in your life?

_____

_____

Goals

What skills would you like to build?

- ☐ Stress management
- ☐ Anxiety management
- ☐ Setting boundaries with others
- ☐ Build self-esteem
- ☐ Create more balance in life
- ☐ Develop better partnering skills
- ☐ Better understand your emotions
- ☐ Anger management
- ☐ Improve sleep
- ☐ Communication skills
- ☐ Conflict resolution
- ☐ Being able to say no
- ☐ Build confidence in skills and abilities
- ☐ Build parenting strategies
- ☐ Skills to manage depression
- ☐ Improved emotional regulation
- ☐ Healing from past traumas
- ☐

Other_____

CURRENT SYMPTOM CHECKLIST

Instructions: Over the **past two weeks**, how often have you been bothered by any of the following symptoms?

0=Not at all 1=Several days 2=More than half the days 3=Nearly everyday

Little interest or pleasure in doing things_____ Feeling down, depressed, or hopeless_____
Trouble falling asleep, staying asleep and/or sleeping too much_____
Feeling tired or having little energy _____
Poor appetite or overeating _____
Feeling bad about yourself, that you are a failure or have let yourself or your family down_____
Trouble concentrating on things, such as reading the newspaper or watching TV_____
Moving or speaking so slowly that other people have noticed, or being so fidgety or restless that you have been moving around more than usual_____
Thoughts that you would be better off dead or hurting yourself in some way_____

Instructions: Over the **past two weeks**, how often have you been bothered by any of the following symptoms?

0=Not at all 1=Several days 2=More than half the days 3=Nearly everyday

Feeling nervous, anxious or on edge_____
Not being able to stop or control worrying_____
Worrying too much about different things_____
Trouble relaxing_____
Being so restless that it's hard to sit still_____
Becoming easily annoyed or irritable_____
Feeling afraid as if something awful might happen_____

Place a check next to the following symptoms that have occurred ***in the past 6 months:***

Group A

- ☐ having a plan for how to end your life
- ☐ feelings of hopelessness
- ☐ severe mood swings
- ☐ lack of personal hygiene or grooming
- ☐ lack of motivation
- ☐ social isolation or withdrawal
- ☐ low self-esteem
- ☐ being unusually irritable
- ☐ difficulty stopping tears
- ☐ feelings of excessive/inappropriate guilt
- ☐ self-injurious or harmful behavior (cutting, scratching, burning)

Group B

- ☐ periods of ***abnormally and persistently*** elevated, high, or irritable mood
- ☐ periods of ***abnormally and persistently*** increased energy or focus on a task
- ☐ significant periods of overblown self-esteem
- ☐ significant periods of feeling grandiose; (that you could do anything)
- ☐ periods of decreased need for sleep ***without feeling tired***
- ☐ more talkative than usual or pressure to keep talking
- ☐ racing thoughts
- ☐ easily distracted by unimportant things
- ☐ *extreme* focus on "getting things done" at school, work, or home.
- ☐ excessive involvement in pleasurable activities that have the potential for painful consequences (spending money, sexual indiscretions, gambling)

Group C

- ☐ being easily fatigued
- ☐ muscle tension
- ☐ irritability as a result of worry
- ☐ sleep disturbance

Group D

- ☐ panic attacks; frequency_____

Symptoms associated with panic attacks: (check all that apply)

- ☐ feelings of choking
- ☐ nausea or abdominal upset
- ☐ numbness or tingling sensations
- ☐ fear of losing control or "going crazy"
- ☐ chest pain or discomfort
- ☐ hot or cold flashes
- ☐ feeling "unreal" or detached from self
- ☐ fear of dying

☐ having to go with others in order to feel comfortable

Group E

☐ considerable fear or anxiety about situations in which you may be judged (e.g. having a conversation; meeting new people)
☐ being observed (e.g. eating or drinking)
☐ performing in front of others
☐ persistent, excessive phobia (heights, closed spaces, specific animals, etc.)
Please list_____
☐ recurrent and bothersome thoughts, ideas, or images that are unwanted and cause anxiety
☐ you have tried to ignore the thoughts or stop them with some other action
☐ repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, repeating) that must be done or you feel anxious
☐ needing to have things done a certain way or the client becomes very upset
☐ the obsessions are time-consuming
☐ recurrent skin picking, resulting in sores
☐ recurrent pulling out of one's own hair, eyelashes, or eyebrows, resulting in hair loss

Group F

☐ experienced, witnessed, or learned of an actual or threatened death, serious injury, or sexual violence
*Traumatic event:_____
☐ recurrent and upsetting thoughts of the trauma
☐ recurrent distressing dreams related to the trauma
☐ flashbacks in which it feels like the trauma is reoccurring
☐ intense or ongoing psychological distress to events that resemble the trauma
☐ intense physical symptoms of panic or fear to events that resemble the trauma
☐ spending effort avoiding thoughts or feelings associated with a past trauma
☐ persistent avoidance of people, places, or activities that cause you to remember the trauma ☐ inability to recall an important aspect of the trauma
☐ persistent negative beliefs (e.g. "I am bad," "No one can be trusted," "The world is not safe")
☐ distorted thoughts about why the trauma happened causing you to blame yourself or others
☐ constantly negative emotional state (e.g. fear, anger, guilt)
☐ marked decreased interest in important activities
☐ feeling detached or distant from others ☐ feeling numb or restricted in your feelings
☐ feeling that your future is shortened ☐ quick startle response
☐ feeling like you are always watching for bad things to happen

Group G

☐ trouble sustaining attention or being easily distracted
☐ lacking attention to detail
☐ restless, fidgety
☐ makes decisions impulsively
☐ trouble maintaining an organized work or living area
☐ difficulty completing projects
☐ feeling overwhelmed by the tasks of everyday living
☐ impatient, easily frustrated
☐ frequent traffic violations or near accidents
☐ inconsistent work performance
☐ procrastinating
☐ making comments to other without considering their impact
☐ difficulty delaying what you want; having to have your needs met immediately

Group H

☐ restriction of food intake that leads to a less than normal body
☐ intense fear of gaining weight or becoming fat event though at a significantly low weight
☐ engaging in persistent behaviors that interfere with weight gain
☐ persistent over concern with body shape and weight
☐ lack of recognition of the seriousness of the current low body weight
☐ recurrent episodes of binge eating large amount of food
☐ eating, in a certain time frame, definitely larger amounts of food than most people would eat in the same time ☐ a sense of lack of control over eating during the episode
☐ recurrent activities such as self-induced vomiting and/or the misuse of laxatives, water pills, strict dieting or excessive exercise

Group I

☐ finding it hard to understand what others are thinking or feeling
☐ getting very anxious about social situations
☐ finding it hard to make friends or preferring to be on your own
☐ seeming blunt, rude, or not interested in others without meaning to
☐ finding it hard to say how you feel
☐ taking things very literally-for example, you may not understand sarcasm or phrases like "break a leg"
☐ having the same routine every day and getting very anxious if it changes
☐ not understanding social "rules", such as not talking over people
☐ avoiding eye contact
☐ getting too close to other people, or getting very upset if someone touches or gets too close to you
☐ noticing small details, patterns, smells, or sounds that others do not
☐ having a very strong interest in certain subjects or activities
☐ liking to plan things carefully before doing them

Group J

☐ seeing things which are not real ☐ hearing sounds or voices which are not real
☐ peculiar behaviors ☐ marked lack of initiative
☐ delusional or bizarre thoughts (thoughts you know others would think are false)
☐ seeing objects, shadows or movements that are not real
☐ periods of time where your thoughts or speech are not connected or do not make sense to you or others
☐ severely impaired ability to function at home or at work
☐ inappropriate mood for the situation (i.e. laughing at sad events)
☐ frequent feelings that someone or something is out to hurt you or discredit you
☐ periods of extreme irritability, physical or verbal aggression or rage

Family Update:

Please list your biological, step, and adopted children:

Name	Age	Living w/you	Name	Age	Living w/you
_____	____	☐ Y ☐ N	_____	____	☐ Y ☐ N
_____	____	☐ Y ☐ N	_____	____	☐ Y ☐ N
_____	____	☐ Y ☐ N	_____	____	☐ Y ☐ N

Are there any other persons living in your home? ☐ Yes ☐ No
If yes, whom?_____

Relationships

Marital Status: (check all that apply)

☐ not currently in a relationship
☐ currently in a relationship (for how long?_____)
☐ engaged (for how long?_____)
☐ married (for how long?_____)
☐ divorced(for how long?_____)
☐ separated (for how long?_____)
☐ divorce in process (for how long?_____)
☐ live-in partner (for how long?_____)
☐ widowed (for how long?_____)
☐ prior marriages(partner)___# of previous marriages

On a scale of 1-10 how would you rate your satisfaction with your relationship?_____

Do you have any concerns that you may be addicted to pornography or have a sex addiction? ☐ No ☐ Yes

Do you have any concerns that your partner may be addicted to pornography or have a sex addiction?
☐ No ☐ Yes

How would you describe your partner? (Check all that apply)

☐ Warm
☐ Understanding
☐ Argumentative
☐ Uncaring
☐ Perfect
☐ Indifferent
☐ Distant
☐ Unpleasant
☐ Tense
☐ Affectionate
☐ Judgmental
☐ Happy
☐ Boring
☐ Unhappy
☐ Unforgiving
☐ Engaging
☐ Abusive
☐ Enjoyable

Relationship Concerns (if any):

☐ past affairs ☐ current affairs ☐ trust issues ☐ poor communication
☐ finances ☐ lack of time together ☐ verbal abuse ☐ physical abuse
☐ substance abuse

Sexual Health:
On a scale of 1-10 how would you rate your sexual satisfaction? _____

Sexual Health Issues:
During foreplay, intercourse, or partnered sexual stimulation, do you experience any of the following? (please check all that apply):

☐ lack of arousal
☐ lack of genital sensation (tingling/warmth/excitement)
☐ difficulty achieving orgasm
☐ loss of orgasm intensity (muffledor short in duration)
☐ vaginal dryness
☐ erectile difficulty
☐ decreased sense of connection with partner
☐ genital pain -If so, please describe_____
☐ lack of focus on/awareness of sexual feelings
☐ lack of desire
☐ difficulty with sexual response (quick, slow, or intermittent)

Substance Use

On average, how often do you drink alcohol?

☐ Never
☐ Once or twice a year
☐ Daily
☐ Once a week
☐ Once a month
☐ Several times a week

On average, when you drink, how much do you drink? ☐ 1-3 drinks ☐ 4-8 drinks ☐ 8 or more

Do you currently have a medical card for the use of marijuana? ☐ No ☐ Yes

Do you currently use CBD in any form? ☐ No ☐ Yes If yes, what form do you use it and how often:

_____

Do you currently use Delta 8? ☐ No ☐ Yes If yes, how often: _____

In the last year, have you experienced any of the following?

Picked up or charged with a drug-related driving offense?	☐ Yes ☐ No
Lost time from school or work because of use?	☐ Yes ☐ No
Experienced a medical problem because of use?	☐ Yes ☐ No
Been fired from a job because of use and its effects?	☐ Yes ☐ No
Felt you ought to cut down on your drinking or drug use?	☐ Yes ☐ No
Do people annoy you by criticizing your drinking or drug use?	☐ Yes ☐ No
Felt bad or guilty about your drinking or drug use?	☐ Yes ☐ No
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes ☐ No

Which of the following substances have you ever used?

☐ None
☐ Cocaine
☐ Bath salts
☐ Crack
☐ LSD
☐ Opium
☐ Heroin
☐ Marijuana
☐ PCP (Angel Dust)
☐ Crank
☐ Methamphetamine
☐ Tranquilizers
☐ Mushrooms
☐ Acid
☐ Pain pills w/o a prescription
☐ Ecstasy/Molly
☐ Inhalants
☐ K2/Spice

Have any of these substances been used in the last 12 months? ☐ No ☐ Yes

If yes, which substances: _____

Substance use status:

☐ no history of abuse ☐ active abuse ☐ early full remission
☐ early partial remission ☐ sustained full remission ☐ sustained partial remission

Since your last episode of care have you participated in any treatment programs? ☐ No ☐ Yes

☐ O*utpatient*: Month/Year_____
Facility:_____
City/State_____

☐ I*npatient:* Month/Year_____
Facility:_____
City/State_____

☐ 12-step program: ☐ stopped on own: ☐ other: _____

Have you ever received a DUI or DWI? ☐ No ☐ Yes /When_____

Do you smoke cigarettes? ☐ No, never have ☐ No, I quit ☐ Yes/How many per day?_____

Do you use a vape or e-cig? ☐ No, never have ☐ No, I quit ☐ Yes/How many times per day?_____

How many caffeinated beverages do you consume daily, on average?
☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Mental Health

Are you currently under the care of a psychiatrist? ☐ No ☐ Yes
If yes, Name: _____Clinic:_____

Have you participated in any other counseling since your last time here?
☐ Individual ☐ Marital ☐ Family
If yes, Name:_____Clinic:_____
Are you willing to sign a release of information for records? ☐ No ☐ Yes

Have you been hospitalized for mental health issues or suicidal thoughts since your last episode of care?
☐ No ☐ Yes/When: _____

Strengths

How would you describe your strengths?

☐ Smart
☐ Funny
☐ Caring
☐ Resourceful
☐ Good work ethic
☐ Well-balanced
☐ Organized
☐ Wise
☐ Enthusiastic
☐ Passionate
☐ Helpful
☐ Multi-tasker
☐ Positive
☐ Good listener
☐ Calm under pressure
☐ Good communicator

Physical Health

Are you currently under the care of a doctor or other health practitioner? ☐ No ☐ Yes
If yes, Name: _____ Clinic:_____

Describe your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Health Issues:_____
_____

Have you had any major illnesses or hospitalizations recently? ☐ No ☐ Yes
If yes, Explain:_____

Current Medications (if any):
Medication_____ Dose: _____
Medication_____ Dose: _____
Medication_____ Dose: _____
Medication_____ Dose: _____

How many hours of sleep do you get on average? ____hours ☐ delayed sleep ☐ early waking

Do you exercise regularly? ☐ No ☐ Yes ☐ Try to

Do you have any known allergies? ☐ No ☐ Yes If yes, please describe:_____
_____