

Dina Yerex, LPC, CADAC III

17356 Strauss Avenue
Sandy, Oregon 97055



406 NE 4th Street
Gresham, Oregon 97030

CLIENT CONCERNS

Name: _____

Today's Date: _____

Please take a few minutes to fill in some information to help me understand your thoughts about what you would like to talk about and accomplish in counseling. If any portion is uncomfortable for you, just leave it blank for now.

Presenting Problem (What brings you in today? In your view, what is the problem?)

How long has this been a problem for you? _____

What has made the situation better? _____

What has made the situation worse? _____

Check any of the following that are a concern or problem for you at this time: (The feelings, thoughts, and behaviors presented below are experienced by many people from time to time—please check any that are an issue for you now)

- | | |
|--|---|
| <input type="checkbox"/> I have no problem or concern bringing me here | <input type="checkbox"/> Depression, low mood, sadness, crying |
| <input type="checkbox"/> Abuse—physical, sexual, emotional, neglect | <input type="checkbox"/> Difficulty enjoying usual activities |
| <input type="checkbox"/> Aggression, violence, fights | <input type="checkbox"/> Difficulty fulfilling responsibilities |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Difficulty relaxing |
| <input type="checkbox"/> Anger, hostility, arguing, irritability | <input type="checkbox"/> Difficulty spending time alone |
| <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Disturbing memories |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Divorce, separation |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Drug use (including prescriptions, over-the-counter) |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Eating problems (overeating, undereating, appetite) |
| <input type="checkbox"/> Career concerns, goals, and choices | <input type="checkbox"/> Energy problems (lack of energy, too much energy) |
| <input type="checkbox"/> Childhood issues | <input type="checkbox"/> Emptiness |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Extreme feelings (extreme happiness, sadness, etc.) |
| <input type="checkbox"/> Confidence issues | <input type="checkbox"/> Failure |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Fatigue, tiredness, low energy |
| <input type="checkbox"/> Compulsions (repetitive behaviors over which you feel little control, including things like computer use, pornography use, shopping, handwashing, cleaning, etc.) | <input type="checkbox"/> Fear when away from home |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Fears, phobias |
| <input type="checkbox"/> Custody of children | <input type="checkbox"/> Feelings easily hurt |
| <input type="checkbox"/> Decision making, indecision, mixed feelings | <input type="checkbox"/> Feeling hopeless |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Feeling worried |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Financial or money troubles |
| | <input type="checkbox"/> Flashbacks |
| | <input type="checkbox"/> Friendships |
| | <input type="checkbox"/> Gambling |

Have you ever had thoughts about hurting yourself or killing yourself? Yes No
If yes, please describe: _____

Have you ever attempted suicide or deliberately injured yourself? Yes No
If yes, please describe: _____

Have you ever had thoughts about hurting or killing someone else? Yes No
If yes, please describe: _____

Have you ever been violent toward someone else? Yes No
If yes, please describe: _____

Have you recently been physically hurt or threatened by someone else? Yes No
If yes, please describe: _____

Counselor Notes:

Previous Mental Health Treatment:

Yes	No	Type	Dates	Provider/Program	Reason for Treatment and Results
		Outpatient Counseling/Therapy			
		Medication for Mental Health			
		Psychiatric Hospitalization			
		Addictions Treatment			
		Self-Help or Support Groups			

Counselor Notes:

Substance Use History

Please list all substances/medications taken, **excluding those taken as prescribed or over the counter medications taken as directed or recommended.**

Substance Type	Current Use (last year)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Methamphetamine								
Tranquilizers								
Heroin or Pain Killers								
PCP/LSD/Mushrooms								
Ecstasy/other Club Drugs								
Inhalants								
Steroids								
Over-the-counter medications								

Have you ever had withdrawal symptoms when trying to stop using substances? Yes No

If yes, please describe: _____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?

Yes No If yes, please describe: _____

Counselor Notes:

Have you ever felt the need to bet more and more money when gambling? Yes No

Have you ever lied to people important to you about how much you gambled? Yes No

Is there any behavior you continue to repeat even though you have tried to slow down or stop it (this might include shopping, internet use, gaming, sex, pornography use, or other behaviors)?

Yes No If yes, please describe: _____

Counselor Notes:

Medical Information

Current Health Concerns/Conditions: _____

Current Prescription and Over-the Counter Medications or Supplements: None

Medication	Dosage	Date First Prescribed	Prescribed By	Reason

Do you have allergies or adverse reactions to any medication? Yes No
If yes, to what medication? _____

Date of last physical exam or visit to medical practitioner: _____

Have you ever had:
Surgery? Yes No If "yes", explain: _____

Significant Illness (including cancer, etc.)? Yes No If "yes", explain: _____

Significant Injury? Yes No If "yes", explain: _____

Head Injury? Yes No If "yes", explain: _____

Counselor Notes:

Strengths: What are you good at? How have you been able to use these to help yourself in the past?

Initial Treatment Plan:

What would you like to see happen as a result of coming here?

How would you know your goals have been achieved—what will be different about your life?

What type of counseling are you seeking (check one)?

- Individual Counseling Couples Counseling Family Counseling

I agree with the above counseling plan with the understanding it can be modified at any time by me, or at my counselor's request and our mutual agreement.

Client Signature

Dina Yerex, LPC, CADC III

Client Printed Name

Date

Date