CLIENT REASSESSMENT

Name:____ Date:_______________________

Please list current medications/vitamins/supplements that you are taking for your mental health:

Medication	Dosage	Reason	Prescribing Doctor
________________	_______	___________	________________
________________	_______	___________	________________
________________	_______	___________	________________
________________	_______	___________	________________
________________	_______	___________	________________

Vitamins & Supplements ____

Health:

Please specify current medical problems ____

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Please specify any problems with sleep____

Please specify any problems with appetite or eating patterns ______________________________

Please specify any current sexual issues ____

Are you exercising? ____ frequency/week____________ type________________________________

Average days/week of alcohol use __________ On typical day, amount of use ___________________

Recreational drug use? ___ If so, frequency _______________ type___________________________

Caffeine use/day (coffee, tea, sodas, chocolate)____

Nicotine use/day (cigarettes, cigars, tobacco chew)____

Symptom Checklist:

Rate current symptoms (0= None, 1=Mild, 2=Moderate, 3=Severe)

___ Aggression/Anger Behavior
___ Alcohol Abuse
___ Anxiety
___ Appetite Changes
___ Anorexic Behavior
___ Bingeing or Purging
___ Bizarre or High Risk Behavior
___ Chest Pains
___ Compulsive Behaviors
___ Computer Addiction
___ Depression
___ Difficulty Concentrating
___ Difficulty Thinking
___ Distractibility
___ Dizziness
___ Drug Abuse
___ Elevated Mood/Mania
___ Fatigue
___ Fears
___ Gambling compulsively
___ Hallucinations or Paranoia
___ Headaches
___ Helplessness
___ Hopelessness
___ Hoarding
___ Hyperactivity
___ Impulsivity
___ Indecisiveness
___ Irritability
___ Loneliness
___ Memory Problems
___ Mood Swings
___ Muscle Tension
___ Obsessive Thoughts
___ Panic Attacks
___ Racing Thoughts
___ Restlessness/On Edge
___ Sexual Addiction
___ Sexual Difficulties
___ Shopping Excessively
___ Sleep Disturbance
___ Social Isolation
___ Suicidal Thoughts
___ Trembling
___ Weight Gain/Less
___ Worrying
___ Worthlessness
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Current stressors (i.e. relationship/family, loss, school, job, unemployment, housing, finances, health, legal)

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Treatment Progress: ☐ None ☐ Minor ☐ Moderate ☐ Major Specify:______________________

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Current counseling goals:____

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