Restoration Counseling Services

Client Self Assessment

Name: _____ Date: _____

Please circle any problem that pertains to you at the present. Indicate the 3 that concern you the most by underlining them.

aggression	financial problems	panic
alcohol use	friendship difficulties	parenting difficulties
anger	family conflict	shame
anxiety	guilt	stomach pain
appetite	grief	suicidal thoughts
bowel problems	hallucinations	sleep problems
career choices	hopelessness	spiritual problems
chest pain	impulsivity	self harm
confusion	inadequacy	separation
concentration	irritability	sexual abuse
crying spells	legal problems	sexual difficulties
depression	loneliness	stress
distractibility	marital conflict	trembling
divorce	memory	unhappiness
drug use	moodiness	violence
eating disorder	meaninglessness	worry
fear	nervousness	work difficulties

Do you think about suicide? ____ yes ____no If yes, do you have a plan? ____yes ____no

Have you ever attempted suicide? ____yes ____no

How often do you drink? _____

When you drink, how much do you usually consume? _____

Please circle other stressors you have experienced in the last 3 years:

Death of a family member	Loss of relationship	Loss of job
Major Illness or injury	Divorce	Major move

Please provide any additional information that may be helpful: _____

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