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Olathe, KS 66062
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**Client Information**

**BASIC INFORMATION**

Name _____ Date of Birth _____

Address _____
Street City State Zip

Employer _____

**Please provide contact phone number(s) and indicate your preferred number.**

_____Leave a message? ___yes ___no preferred? ___yes ___no
Home Phone

_____Leave a message? ___yes ___no preferred? ___yes ___no
Cell Phone

_____Leave a message? ___yes ___no preferred? ___yes ___no
Work Phone

_____ OK to E-mail? ___yes ___no OK to Text? ___yes ___no
E-mail Address

Referred by _____

Do I have your permission to thank the person who referred you? ___yes ___no

**RELIGIOUS AND SPIRITIUAL**

Do you consider yourself spiritual? ___yes ___no Religious? ___yes ___no

Comment? _____

Do you currently express this spirituality through religious practice? ___yes ___no

Comment? _____

Would you like spirituality included in your counseling? ___yes ___no

**BACKGROUND AND PRESENTING PROBLEM**

Occupation (s) _____

Marital Status _____ If married, how long? _____

If you have been married before, please provide dates for marriage(s), separation(s) and divorce(s):

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Please describe the problem or situation which led you to seek services at this time:

How long has this been a problem? _____

Have you experienced this type of problem before? _____ If so, when? _____

Have you had counseling before? _____ If so, when and why?

Was it helpful? _____ If not, why not? _____

Have you ever had medication prescribed for psychiatric or emotional difficulties? _____

If so, please list _____

Have any other biological relatives had problems similar to yours, or had any psychiatric or emotional difficulties? ___yes ___no

If so, which relatives and what kind of problems?

Presenting problems: (check all that apply – if attending couples counseling please put your initials next to the problems that apply)

- Very unhappy
- Irritable
- Temper outbursts
- Withdrawn
- Daydreaming
- Fearful
- Worry
- Overactive
- Slow
- Short attention span
- Distractible
- Lacks initiative
- Undependable
- Social problems
- Crying spells
- Hair Pulling
- Impulsive
- Stubborn
- Panic attacks
- Lying
- Mean to others
- Destructive
- Trouble with the law
- Health problems
- Self-mutilating
- Stressed out
- Relationship problems
- Shy
- Strange behavior
- Strange thoughts
- Physical abuse
- Sexual abuse
- Parenting problems
- Stealing
- Repetitive/ritualistic behaviors
- Grief
- Employment problems
- Financial stress
- Legal problems
- Violence
- Eating problems
- Sleeping problems
- Sexual problems
- Drug use
- Alcohol use
- Suicidal thoughts
- Homicidal thoughts

Explain

What are your goals for treatment?

Is there anything else you feel is important for your counselor to know?

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

**Name:** _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

*If this questionnaire is completed by an informant*, **what is your relationship with the individual?** _____
**In a typical week, approximately how much time do you spend with the individual?** _____ **hours/week**

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

| | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |

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