Options
Counseling and Family Services

Client #:_____

BEHAVIORAL HEALTH INFORMATION

What services are you seeking? _____ Therapy _____ Med Management _____ Skills Training

What is the main reason you're seeking services at this time? _____

_____

_____

Please mark any concerns you or your child have in the following areas.
(Select only those that apply to the client).

_____ sad, depressed
_____ cry easily
_____ mood swings
_____ can't sleep
_____ sleeping too much
_____ tired often
_____ muscle tension
_____ can't eat
_____ eating too much
_____ feel anxious, nervous
_____ panic/anxiety attacks
_____ often fearful, afraid
_____ easily startled
_____ feel overwhelmed
_____ worry often
_____ feel stressed
_____ feel worthless
_____ easily angered
_____ aggression
_____ irritability
_____ obsessive behaviors
_____ self harm behaviors
_____ thoughts of suicide
_____ nightmares
_____ flashbacks
_____ can't remember things
_____ can't concentrate
_____ hyperactivity
_____ problems learning
_____ hearing voices
_____ seeing things that are not there
_____alcohol/drug use

The following symptoms affect or may be affected by your (or your child's) behavioral health needs. Please check if any of the following are currently affecting your life.

_____ moving
_____ housing concerns
_____ homeless
_____ job loss
_____ death/grief
_____ concerns about children
_____ child with special needs
_____ abuse in family
_____ domestic violence
_____ alcohol/drugs in family
_____ concerns about a parent
_____ family conflicts
_____divorce
_____relationship concerns
_____pregnancy
_____physical health concerns
_____legal issues/criminal record