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Aaron - Client Update

ECR #

Options
Counseling and Family Services

Client Update

Parent's Name : **Todays Date :**

Client's Name : **Date of Birth :**

Brief Mood Survey

Please indicate how you've been feeling over the last **7 Days,** including today.

1- Sad or down in the dumps

- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

2- discouraged or hopeless

- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

3- Low self-esteem

- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

4- Worthless or inadequate

- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

5- Loss of pleasure / satisfaction in life

- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot

○4 - Extremely

Total Items 1-5 : _____

Suicidal Urges

1- Do you have any suicidal thoughts?

○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

2- Would you like to end your life?
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

Total items 1-2 : _____

Anxiety

1- Anxious

○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

2- Frightened
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

3 - Worrying about things over & over
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

4 - Tense or on edge
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

5 - Nervous
- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

Total items 1-5 :_____

Panic

1 - Sudden feelings of terror or overwhelming fear.

- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

2 - Sudden, terrifying panic attacks that come out of the blue.
- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

3 - Suddenly feeling you're going crazy or cracking up.
- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

4 - Suddenly feeling you're about to suffocate or pass out.
- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

5 - suddenly feeling you'll have a stroke, heart attack or die.
- ○0 - Not at all
- ○1 - Somewhat
- ○2 - Moderate
- ○3 - A Lot
- ○4 - Extremely

Total Items 1 - 5 :_____

Anger

1 - Frustrated

○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

2 - Annoyed
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

3 - Resentful
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

4 - Angry
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

5 - Irriated
○0 - Not at all
○1 - Somewhat
○2 - Moderate
○3 - A Lot
○4 - Extremely

Total items 1-5 :____

Impulsivity & concentration

1 - Impulsivity ○Not at all○Somewhat○Moderate○A Lot○Extremely

2 - Difficulty concentrating, careless mistakes ○Not at all○Somewhat○Moderate○A Lot○Extremely

3 - Restless, fidgety, can’t sit still ○Not at all○Somewhat○Moderate○A Lot○Extremely

4 - Easily bored, trouble finishing things ○Not at all○Somewhat○Moderate○A Lot○Extremely

Total items 1-4 :____

Current medication & Reason	Max Dose	Dates Taken

Review of Systems - please check if you have **NEW** symptoms or medical problems in the following areas.

☐ None☐ Weight loss☐ Weight gain☐ Insomnia☐ Chronic Fatigue

☐ Loss of Hearing☐ Seasonal Allergies☐ Sinus Pain☐ ringing in Ears
☐ Chest Pain☐ Hypertension☐ Edema☐ Palpitations☐ High Cholesterol
☐ Asthma☐ Wheezing☐ Frequent Cough
☐ Heartburn / indigestion☐ Ulcer☐ Abdominal Pain☐ Stomach Bleed☐ constipation☐ diarrhea
☐ Arthritis☐ Muscle Weakness☐ Joint Pain☐ Back Pain
☐ Rash☐ Ulcers☐ Scars
☐ Headaches☐ Seizures☐ Numbness☐ Dizziness☐ Problem Walking
☐ None☐ Depression☐ Mood Swings☐ Anxiety
☐ None☐ Diabetes☐ Hyperthyroid☐ Hot Flashes
☐ Easy Bruising☐ Bleeding☐ Heat or Cold Intolerance☐ Anemia☐ Other

Do You have physical pain?

○Yes
○No

IF yes, pain location :

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is there anything else that would be helpful for your provider to know?

X

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