Relational Connections

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Client Initial Self Evaluation

Name:_____ D.O.B._____ Today's Date: _____

To assist us in providing with the best care it would be helpful if you would rank the following items. We may ask you to complete a similar survey in a few months to assess if there have been changes since intake into therapy. This information will remain confidential. Please raise any questions with your therapist.

Please circle the number that reflects how much an area is a current problem for you in the last two weeks:

		Mild----------				----------Severe
Anxiety	None	1	2	3	4	5
Depression	None	1	2	3	4	5
Thoughts of self-harm	None	1	2	3	4	5
Low self-esteem	None	1	2	3	4	5
Family problems	None	1	2	3	4	5
Problems related to rape or sexual abuse	None	1	2	3	4	5
Health problems	None	1	2	3	4	5
Difficulty controlling anger	None	1	2	3	4	5
Domestic abuse	None	1	2	3	4	5
Sexual concerns	None	1	2	3	4	5
Problems with isolation or social support	None	1	2	3	4	5
Difficulty coping with stressors	None	1	2	3	4	5
Employment/career concerns	None	1	2	3	4	5

Other Problems_____