WINNING AT HOME

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Self-Assessment Form

CONFIDENTIAL

Client Name: _____ **Person who this form is about:** _____

Person filling out form: _____ **Relationship to client:** _____ **Date:** _____

Use the scale below to indicate the level of distress with the following items by circling the number corresponding to the response. Please rate all issues that apply.

ANXIETY/DEPRESSION	No Concern	Minimal		Moderate		Urgent
Issues with appetite	0	1	2	3	4	5
Issues with eating	0	1	2	3	4	5
Fear of harming others or yourself (Suicidal thoughts)	0	1	2	3	4	5
Irritability, anger, hostility	0	1	2	3	4	5
Perfectionism	0	1	2	3	4	5
Loss of motivation or ambition	0	1	2	3	4	5
Panic attacks	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Symptoms of stress (headaches, nausea, difficulty concentrating, etc.)	0	1	2	3	4	5
Loneliness	0	1	2	3	4	5
Low self-esteem	0	1	2	3	4	5
Negative or critical thinking	0	1	2	3	4	5

Additional Comments:

Form continues on back side

RELATIONSHIPS

	No Concern		Minimal	Moderate		Urgent
Communication concerns	0	1	2	3	4	5
Divorce/Separation	0	1	2	3	4	5
Financial concerns	0	1	2	3	4	5
Loss of significant person/relationship	0	1	2	3	4	5
Parenting concerns	0	1	2	3	4	5
Difficulty with friends	0	1	2	3	4	5
Difficulty with family/parents/children	0	1	2	3	4	5
Difficulty with spouse/partner	0	1	2	3	4	5
Sexual or intimacy concerns	0	1	2	3	4	5

Additional Comments:

GENERAL

	No Concern		Minimal	Moderate		Urgent
Addictive concerns (pornography/sex, food, gambling, shopping, etc.)	0	1	2	3	4	5
Substance abuse (Drugs, alcohol, nicotine, caffeine, etc.)	0	1	2	3	4	5
Substance abuse within the family	0	1	2	3	4	5
Grief Issues (death, loss, etc.)	0	1	2	3	4	5
Losing contact with reality	0	1	2	3	4	5
Survivor of abuse (trauma)	0	1	2	3	4	5
Occupational or school related stress	0	1	2	3	4	5

Additional Comments: