

# Restoration Counseling Services

## Client Self Assessment

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please rate the difficulty that you or any family members have with any of the following areas, then circle the three that concern you the most. If you are rating for a family member, indicate who it is. (leave blank any areas that do not apply)

<u>Rating Scale</u>									
1	2	3	4	5	6	7	8	9	
mild				moderate				severe	
___ aggression				___ fear				___ nervousness	
___ alcohol dependence				___ financial problems				___ panic	
___ anger				___ friendship difficulties				___ parenting difficulties	
___ anxiety				___ family conflict				___ shame	
___ appetite				___ guilt				___ stomach pain	
___ bowel problems				___ grief				___ suicidal thoughts	
___ career choices				___ hallucinations				___ sleep problems	
___ chest pain				___ hopelessness				___ spiritual problems	
___ confusion				___ impulsivity				___ separation	
___ concentration				___ inadequacy				___ sexual abuse	
___ crying spells				___ irritability				___ sexual difficulties	
___ depression				___ legal problems				___ trembling	
___ distractibility				___ loneliness				___ unhappiness	
___ dizziness				___ marital conflict				___ violence	
___ divorce				___ memory				___ worry	
___ drug dependence				___ moodiness				___ work difficulties	
___ eating disorder				___ meaninglessness					

Please briefly describe the issues or problems that are most difficult for you: \_\_\_\_\_

---

---

---

---