Client Name: Date:

Client Questionnaire

On a 0-10 scale, please rate the following: (0 = not experiencing, 10 = unmanageable/severe)

-Anxiety	0	1	2	3	4	5	6	7	8	9	10
-Depression	0	1	2	3	4	5	6	7	8	9	10
-Hopelessness	0	1	2	3	4	5	6	7	8	9	10
-Helplessness	0	1	2	3	4	5	6	7	8	9	10
-Worthlessness	0	1	2	3	4	5	6	7	8	9	10

Are you experiencing any of the following withdrawal symptoms? (Circle all that apply)

Anxiety	Depression	Agitation	Irritability	Restlessness	Restless legs	Headaches
Body aches	Sweating	Fatigue	Insomnia	Panic attacks	Lack of appetite	Nausea
Tremors	Pins/Needles	Tingling in extremities	Difficulty concentrating	Anhedonia	Mental Fog	Mood swings
Guilt	Hopelessness	Helplessness	Worthlessness	Racing heart	Stress Sensitivity	Racing thoughts
Impaired cognitive function	Lack of motivation/ initiative	Forgetfulness	Emotional Numbness	Vomiting	Chills	Nightmares
Racing heart	Restlessness	Sense of detachment	Tearfulness	Emotional outbursts	Anger	Excessive sleep
Low frustration tolerance	Hallucinations	Obsessive thoughts	Hyperarousal	Mania	Other:	

Are you having any of the following:
-Suicidal thoughts Yes or No
-Homicidal thoughts Yes or No
-Thoughts of harming yourself Yes or No

Please explain anything marked "Yes" above: _____

_____

_____

Do you think your medications are effective? _____

_____