CHARIS
counseling associates

CLIENT CHECK-IN FORM

CONFIDENTIAL

NAME: _____ DATE: _____ TIME: _____

What purpose or goal do you want to focus on today? _____

_____

- ☐ *Assessment*
- ☐ *Decrease Symptoms*
- ☐ *Discuss Current Event(s)*
- ☐ *Discuss Past Event(s)*
- ☐ *Goal-setting / Treatment Planning*
- ☐ *Improve Relationship(s)*
- ☐ *Other:*
- ☐ *Increase Coping Skills*
- ☐ *Parenting Assistance*
- ☐ *Prepare for Ending Treatment*
- ☐ *Questions for the Counselor*
- ☐ *Referral*
- ☐ *Safety Planning*

What significant changes *(for example: activity, appetite, coping ability, health, mood, progress, relationships, school, sleep, stress, substance use, symptoms, thinking, work, etc.)* have you experienced since your last appointment? _____

_____

Which of these changes should be added to your current treatment plan? _____

_____

How would you describe your current stress level, on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10
Low Medium Extremely High

How would you describe your current coping ability, on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10
Low Medium Extremely High

What have you tried since your last appointment that has helped, even a little? _____

_____

Do you (or anyone attending this session) have thoughts of self-harm, suicide or violence?

- ☐ *Yes, please describe:* _____
- ☐ *No*

Have you had any recent medication changes?

- ☐ *Yes, please describe:* _____
- ☐ *No*

Do you need to discuss your insurance or bill, paperwork, reports, or contacting someone else?

- ☐ *Yes, please describe:* _____
- ☐ *No*