

Name:
Therapist ID:

Session:
Client #:

AUBURN MFT CLINIC: *Family Adult Follow-up*

This section will focus on your individual symptoms related to depression and anxiety over the last 2 weeks.

	<i>Not at All</i>	<i>Several Days</i>	<i>More than Half the Days</i>	<i>Nearly Every Day</i>
1. Little interest or pleasure in doing things.....0	1	2	3	3
2. Feeling down, depressed, or hopeless0	1	2	3	3
3. Trouble falling or staying asleep, or sleeping too much0	1	2	3	3
4. Feeling tired or having little energy0	1	2	3	3
5. Poor appetite or overeating0	1	2	3	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down0	1	2	3	3
7. Trouble concentrating on things, such as reading the newspaper or watching television0	1	2	3	3
8. Moving or speaking so slowly that other people could have noticed; Or being so fidgety or restless that you have been moving around a lot more than usual0	1	2	3	3
9. Thoughts that you would be better off dead, or of hurting yourself.....0	1	2	3	3

	<i>Not Difficult</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
10. How difficult have these problems made it for you to do your work, take care of the home, or get along with others? 0	1	2	3	3

	<i>Not at All</i>	<i>Several Days</i>	<i>More than Half the Days</i>	<i>Nearly Every Day</i>
11. Feeling nervous, anxious or on edge.....0	1	2	3	3
12. Not being able to stop or control worrying0	1	2	3	3
13. Worrying too much about different things0	1	2	3	3
14. Trouble relaxing.....0	1	2	3	3
15. Being so restless that it is hard to sit still0	1	2	3	3
16. Becoming easily annoyed or irritable0	1	2	3	3
17. Feeling afraid as if something awful might happen0	1	2	3	3

	<i>Not Difficult</i>	<i>Somewhat</i>	<i>Very</i>	<i>Extremely</i>
18. How difficult have these problems made it for you to do your work, take care of the home, or get along with others? 0	1	2	3	3

<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>
<i>Never</i>	<i>Once</i>	<i>Twice</i>	<i>3-5 Times</i>	<i>6-10 Times</i>	<i>11-20 Times</i>	<i>More than 20 Times</i>	<i>Happened but Not in Past Year</i>

Using the following key, how often did **YOU** do the following during the PAST 4 WEEKS?

1. Threw something (but not at a family member) or smashed something0	1	2	3	4	5	6	7
2. Threatened to hit or throw something at a family member0	1	2	3	4	5	6	7
3. Threw something at family member0	1	2	3	4	5	6	7
4. Pushed, grabbed, or shoved a family member.....0	1	2	3	4	5	6	7
5. Hit (or tried to hit) a family member but <i>not</i> with anything hard0	1	2	3	4	5	6	7
6. Hit (or tried to hit) a family member with something hard0	1	2	3	4	5	6	7

Using the same key as above, how often did **YOUR CHILD** do the following during the PAST 4 WEEKS?

1. Threw something (but not at a family member) or smashed something0	1	2	3	4	5	6	7
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2. Threatened to hit or throw something at a family member	0	1	2	3	4	5	6	7
3. Threw something at family member	0	1	2	3	4	5	6	7
4. Pushed, grabbed, or shoved a family member.....	0	1	2	3	4	5	6	7
5. Hit (or tried to hit) a family member but <i>not</i> with anything hard	0	1	2	3	4	5	6	7
6. Hit (or tried to hit) a family member with something hard	0	1	2	3	4	5	6	7

The next section will focus on behavior of the child with the presenting problem in therapy.

Please rate the degree to which your child has experienced the following problems in the past **30 days**.

	<i>Not at All</i>	<i>Once or Twice</i>	<i>Several Times</i>	<i>Often</i>	<i>Most of the Time</i>	<i>All of the Time</i>
1. Arguing with others.....	0	1	2	3	4	5
2. Getting into fights.....	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others.....	0	1	2	3	4	5
4. Fits of anger.....	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason.....	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes.....	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills).....	0	1	2	3	4	5
13. Talking or thinking about death.....	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends.....	0	1	2	3	4	5
16. Feeling anxious or fearful.....	0	1	2	3	4	5
17. Worrying that something bad is going to happen.....	0	1	2	3	4	5
18. Feeling sad or depressed.....	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

Rate the degree to which your child's problems affect his or her current ability in activities. Consider your child's level of functioning.

	<i>Extreme Troubles</i>	<i>Quite a few Troubles</i>	<i>Some Troubles</i>	<i>OK</i>	<i>Doing Very Well</i>
1. Getting along with friends	0	1	2	3	4
2. Getting along with family.....	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends.....	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good.....	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble.....	0	1	2	3	4
8. Being motivated and finishing projects.....	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school.....	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions.....	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks.....	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4

