Connie McCullar, M.S., LMFT 90573
1148 Alpine Rd. Ste 205
Walnut Creek, CA 94596
(925) 285-6595
cfmccullar@yahoo.com
www.mccullarpsychotherapy.com

CLIENT PRE-SURVEY

Name: _____ Date: _____

How well do you feel you function on a daily basis? Please use the following scale to answer below:

10 Functioning very well in life with no problems
9 Expectable problems in life
8 Mild problems, little impact on life
7 Mild symptoms with mild impact on life
6 Moderate symptoms with moderate impact on life
5 Serious problems in life
4 Problems seriously impair daily life
3 Not able to function on a daily basis
2 Some danger to self or others
1 Serious danger of hurting self or others

RIGHT NOW _____ HIGHEST LEVEL IN LAST YEAR ____ LOWEST LEVEL IN LAST YEAR _____

Check the areas of your life that bring you to therapy. Please use the following scale. 1=mild concern 2=moderate concern 3= serious concern

	Access to Health Care		Identity Issues
	Access to Community Resources		Irritability/Moodiness
	Anger		Job/Career/School
	Anxiety		Managing boundaries with others
	Body Image		Obsessive Thoughts
	Child of Substance Abuser		Panic Attacks
	Coming Out		Peer Relationships
	Communication Skills		Personal Growth
	Compulsive Behavior		Physical Complaints
	Conflict Resolution		Stress
	Death of Friend or Family Member		Relationship – maintaining a healthy one
	Decreased Energy		Relationship Problems
	Depression		Self-esteem
	Diagnosed Medical Condition		Sexual Function
	Disturbing Thoughts		Sleep Problems

	Domestic Violence		Social Activities
	Eating Problems		Substance Use
	Family		Substance Abuse of Another Person
	Feeling Isolated		Substance Abuse Recovery
	Financial Situation		Target of Hate Crime
	Friendships		Transitioning/Transgender
	Gender Issues		Unsafe Sex
	Grief		Witness to Violence
	History of Child Abuse		Other -

Mark each of the following that you consider as part of *your* support group:

	Partner or Spouse		Support Group
	Circle of Friends		Community
	One Close Friend		Co-Workers
	Group of Acquaintances		Therapist/Service Provider
	Parents		Religious (minister, rabbi, priest, etc.)
	Sisters/Brothers		None
	Extended Family		Other
	Family of Choice		

Mark which of the following you consider your strengths:

	Intelligent		Spiritual		Optimistic
	Committed/Loyal		Integrity		Hard-working
	Compassionate/ Thoughtful		Honest		Good self-esteem
	Supportive/Giving		Good listener		Good leader
	Trusting		Good follower		Courageous
	Sensitive		Motivated		Able to express feelings
	Patient		Strong		Ability to cope
	Modest		Responsible		Ability to handle stress
	Insightful		Outgoing		Sense of humor
	Socially connected		Independent		Creative
	Easy Going		Assertive		None
	Other -				

THANK YOU FOR FILLING OUT THIS PRE THERAPY SURVEY.